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JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., North, Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 8, 1917, and authorized July 15, 1918.

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Subscription, $5.00 per year; $1.00 single copy.
EDITORIAL AND ADVERTISING OFFICE, Journal of the American Medical Women's Association, 1790 Broadway, New York 19, N. Y. Telephone Judson 6-8683. Advertising Manager, Joseph Bourgholtzer, Box 281, Suffern, N.Y. Telephone Lafayette 9-3044 (Mahwah, New Jersey).

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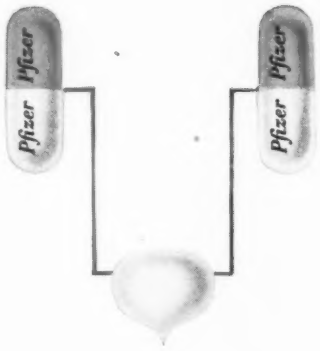

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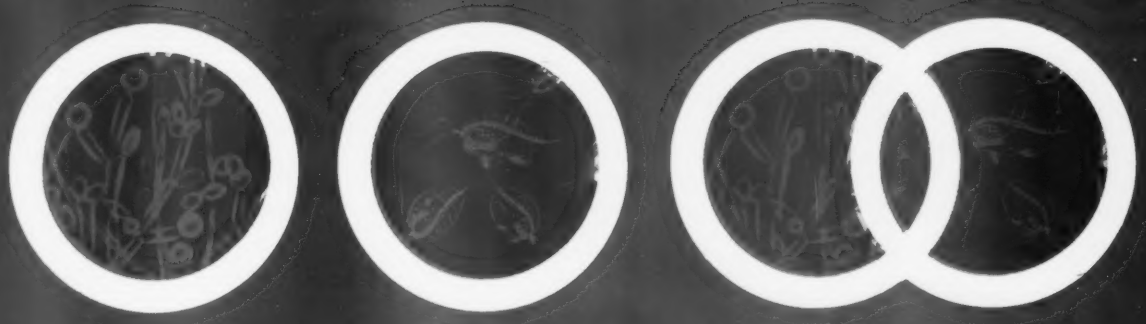

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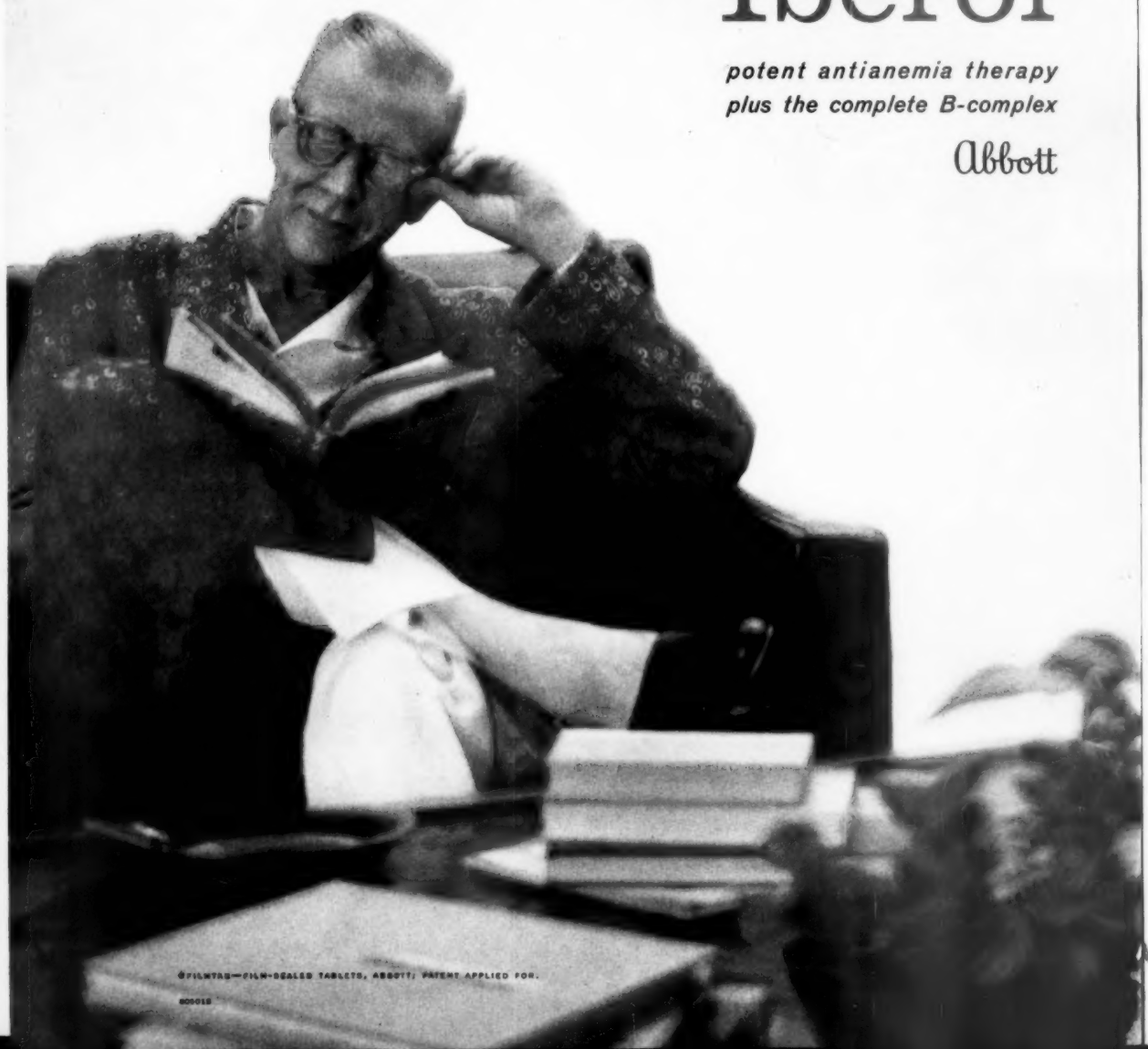

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(Continued on page 14)

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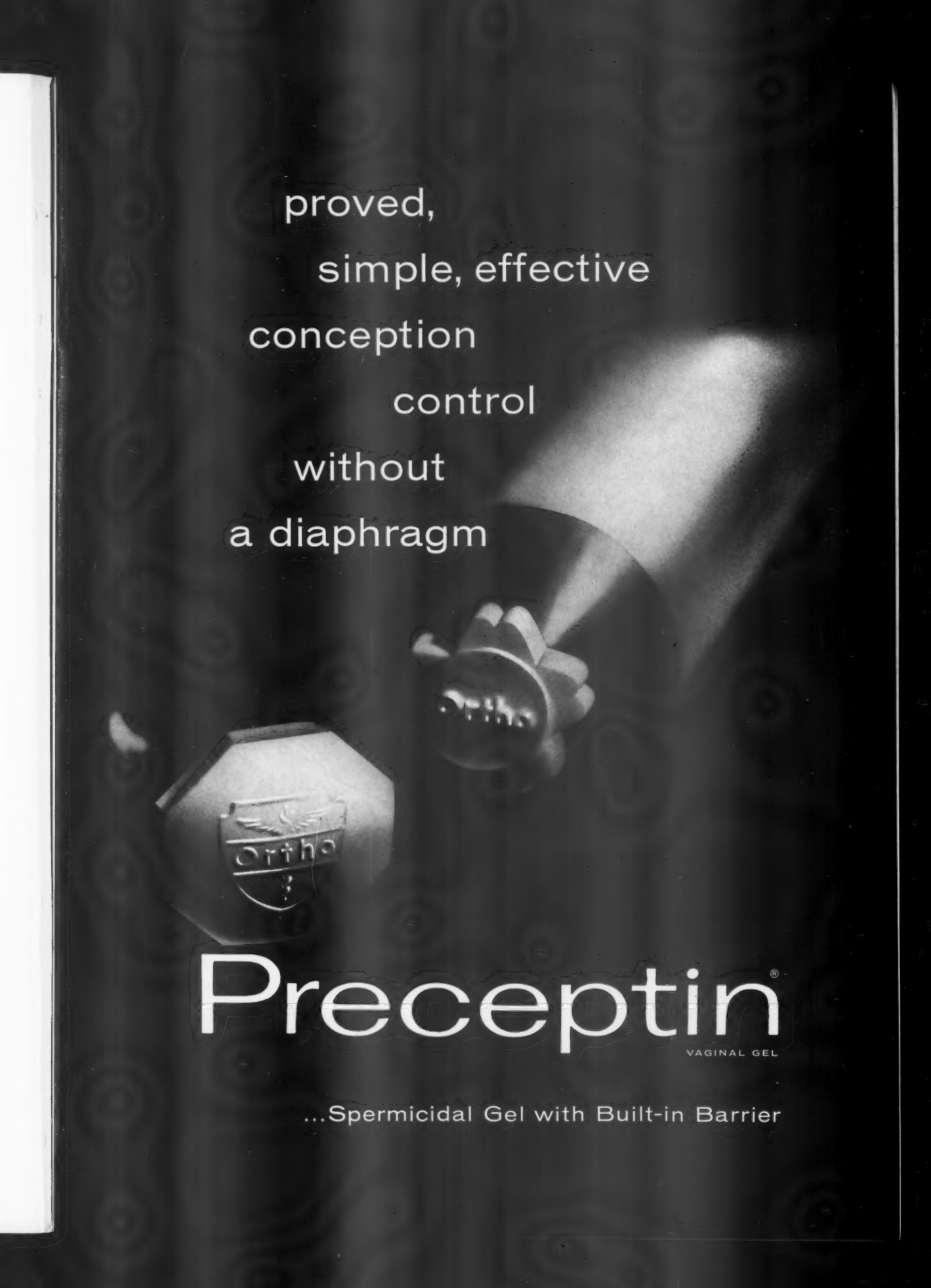
(Continued on page 18)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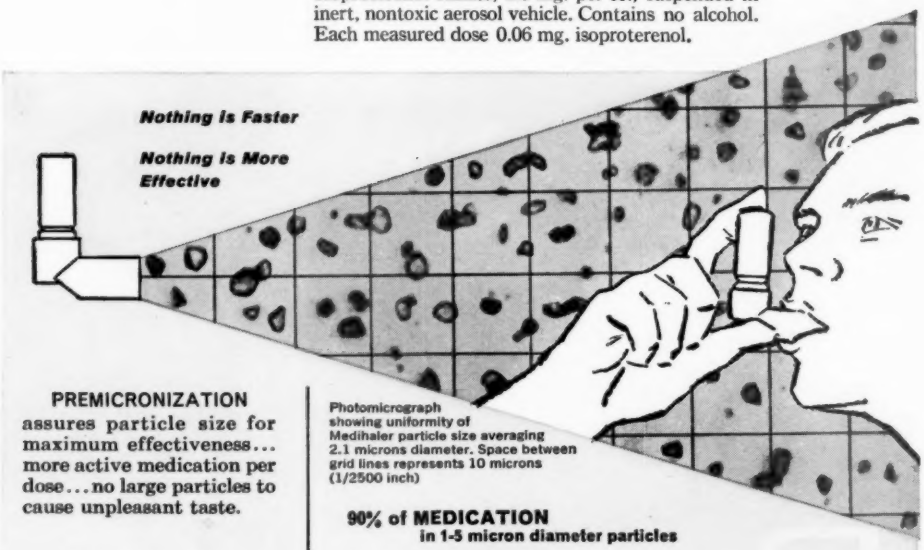

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1. *Eisfelder, H.W.: Am. Pract. & Dig. Treat.* 5:778 (Oct. 1954)
2. *Freed, S.C.: G.P.* 7:63 (1953)
3. *Sherman, R.J.: Medical Times,* 82:107 (Feb. 1954)

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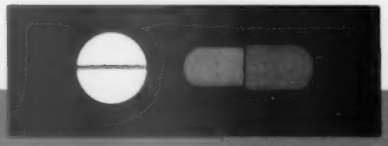

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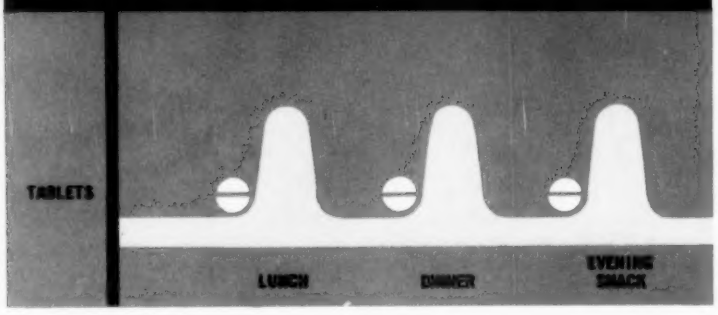

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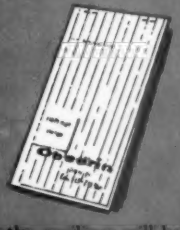

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(Continued on page 20)

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*Rock, J.; Pincus, G., & Garcia, C. R.: *Science* 124:891 (Nov. 2) 1956.

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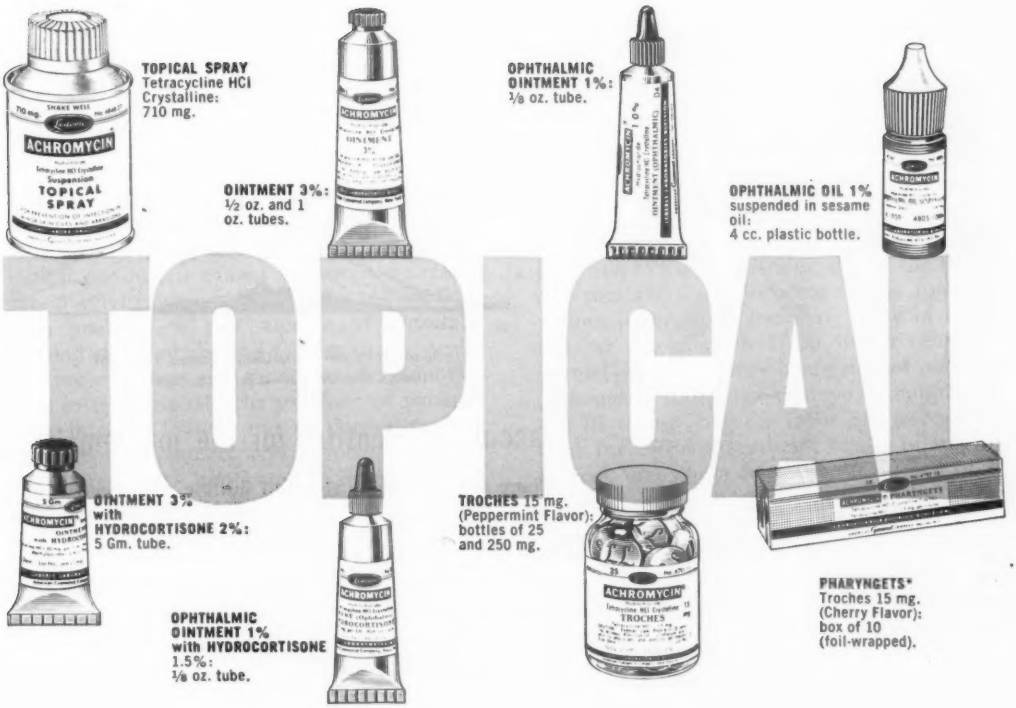

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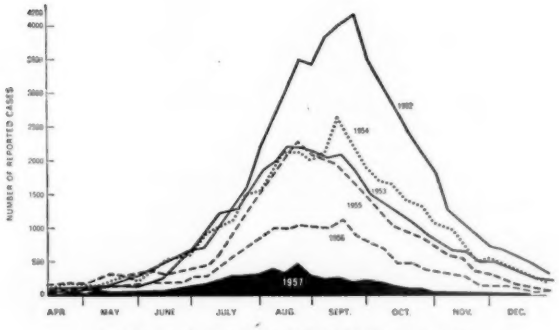

Incidence of polio in the United States, 1952-1957
(data compiled from U.S.P.H.S. reports)

vaccine is plentiful for the job remaining

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1. J. A. M. A., 165:21 (*November 23*), *1957.*

2. Department of Health, Education, and Welfare: News Release, October 10, 1957.

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

Volume 13 JUNE, 1958 Number 6

Antibiotic-Resistant Staphylococci—A Health Department Survey

Mary B. Dale, M.D., D.P.H.

THERE IS MUCH INTEREST and concern at present in the stubborn problem posed by the severity and persistence of a variety of pathological conditions caused by antibiotic-resistant staphylococci *(Micrococcus pyogenes)*. The problem is met chiefly in hospitals. Among the contributing factors to the problem are the kinds and quantities of antibiotics used in the hospital,[1] the presence of patients with infected lesions, and the large numbers of susceptible patients who are unable to cope with infections.[2] Implicated in spreading the organisms are the techniques used in cleaning the wards and laundering the hospital linen, and the professional procedures used by medical and nursing staffs in the care of the patient. The most important agents in the spread of the organism are considered the nose and throat carriers of antibiotic-resistant staphylococci among hospital personnel.[3]

Dr. Dale is Chief of the Division of Acute Communicable Diseases, Los Angeles County Health Department.

The following data from published statistics give an over-all idea of the proportion of carriers of potential pathogenic (coagulase-positive) staphylococcal strains and of the antibiotic-resistant staphylococcal strains found in various populations, including those of hospitals. At any moment 25 to 50 per cent of a normal population may be carriers of potential pathogenic (coagulase-positive) staphylococci.[3] In taking cultures from various populations for antibiotic-resistant strains of staphylococci, one study showed an incidence of 32 per cent among hospital personnel and 4 per cent in a blood donor clinic[4]; another study showed an incidence of 8.6 per cent among university students, 29.9 per cent among hospital outpatients, 75.4 per cent among hospital inpatients, and as high as 80.6 per cent[1] or 85 per cent[5] among hospital attendants.

In view of a universal occurrence of carriers of potential pathogenic staphylococci, including antibiotic-resistant organisms, and assuming that in a health department group the latter strains might be more numerous than in a normal population because of the semimedical character of the work, it was considered advisable to make a spot check of the

personnel of the Los Angeles County Health Department for evidence of such carriers. There was, moreover, a practical motive for conducting such a survey. In April, 1957, it became known that a public health nurse (E.L.), employed in the health department since October, 1956, had been a persistent carrier of an antibiotic-resistant staphylococcal strain. The carrier condition had been acquired at her former place of employment, a veterans hospital in another state. Subsequent culture of her nose and throat revealed that she was still a carrier of a resistant staphylococcal strain. Administrative questions arose as to what effect her carrier status should have on her professional activities in the health department.

The questions thought to be of importance to the survey were: 1. What proportion of health department employees are antibiotic-resistant staphylococcal carriers? 2. What proportion of nurses on the staff are antibiotic-resistant staphylococcal carriers? 3. Are nurses more apt to be carriers of potential pathogenic staphylococci than persons in other health center classifications? 4. Is there evidence of person to person spread of the carrier condition among the health center personnel? 5. Are patients in the health center, especially infants, at risk because of staphylococcal carriers among the nurses, or are maternal and child health clinics, attended as they are by many recently hospitalized mothers and infants, a source of staphylococcal exposure to the nurses? 6. Are venereal disease and tuberculosis clinics sources of infection from resistant strains of staphylococci because of the patients treated with penicillin and streptomycin who gather there? 7. Should there be changes in our nursing procedures to deal with the presence of antibiotic-resistant staphylococcal carriers on the staff?

These seemed practical questions; therefore, we sought to furnish as pertinent answers as limited time and personnel would allow. It was decided to take a nose and throat culture survey of the personnel in each of two health centers, designated here as center A and center B. Center A was E.L.'s place of employment, and center B was chosen as a control since it maintained a staff comparable in size to that of center A. In particular, the nursing staff in each center contained equal numbers of 25 nurses. The 117 persons to be surveyed in this manner represented 13.6 per cent of the entire health department staff.

METHODS

Between April 30 and May 22, 1957, nose and throat swabs were obtained from 117 persons of the staffs in two health centers: from 54 persons in center A, and from 63 persons in center B. Seven additional persons, relatives of E.L., were examined in the survey at center A.

The swabs were immediately streaked on Löffler's slants. Nose and throat swabs from each person were combined on a single slant. The latter were delivered to the laboratory and incubated overnight at 37 C. The growth appearing on a slant was streaked on a plate of Bacto Chapman Stone medium and incubated at 37 C for 48 hours. The medium was examined for golden pigmented colonies and also for "clearing." A platinum wire was used to transfer representative numbers of suspected staphylococci to tubes of brain-heart infusion broth and to nutrient agar slants. A coagulase test was made from the 18 to 24 hour broth culture. If the latter proved positive, an antibiotic sensitivity test was carried out on agar plates, using an inoculum from the broth culture and employing Bacto Unidisks (high concentration, code 7003). Since the Unidisks used in this study included penicillin, streptomycin, chlortetracycline, chloramphenicol, oxytetracycline, tetracycline, and erythromycin but did not include novobiocin, individual discs containing this antibiotic were placed in the center of the plates. Single colonies of the coagulase-positive strains were typed by the phage method.[6]

A questionnaire form, given to each person surveyed, listed the following information: identification and official position, work assignment during the former 10 months, kind and extent of illness or infection with days lost from work thereby during the same period, medicaments received, and periods of hospitalization.

RESULTS

Analysis of the data resulting from the survey of the health centers gave information more gratifying than had been expected, since only a small problem was revealed. There was no significant difference in results on nose and throat cultures between centers A and B. In fact, coagulase-positive cultures were slightly fewer from center A than from center B (38.8 per cent against 42.6 per cent, as shown in table I). There were four cultures contain-

TABLE I

Culture Results from Center A and Center B

Health Center	Persons Cultured, No.	Coagulase-Positive Cultures No.	%
A	54	21	38.8
B	63	26	42.6

ing antibiotic-resistant staphylococci (two from each center).

The statistical data of centers A and B were combined for numerical advantage in order to compare the results of cultures from different classifications of employees in these two centers. The four broad classifications of health department personnel in centers A and B were set up as follows: public health nursing, clerical, sanitarian, and unclassified. The results are summarized in table II, which presents laboratory results on cultures from the 117 persons on the combined staffs of centers A and B. In 77.8 per cent of the cultures, gram-positive cocci were found. Over half (47) of the gram-positive cocci cultures, or 40.2 per cent of all cultures, were coagulase-positive strains, and they included four antibiotic-resistant strains. The four antibiotic-resistant strains were 3.4 per cent of the total cultures. These resistant strains came solely from the 2 public health nursing cultures and constituted 8 per cent of that classification. Although 40 per cent of the cultures from the nursing group were coagulase-positive strains of staphylococci, the sanitarians had the highest rates—47.4 per cent. Both percentages are within normal limits.

Cultures from the clerical and unclassified groups yielded the lowest rates of coagulase-positive staphylococcal strains: 36.0 per cent and 39.1 per cent respectively. The unclassified group included many smaller groups, such as physicians, dentists, medical social workers, registrars, telephone operators, and custodians. The physicians and dentists numbered seven; hence, their numbers were too small as a group for significant comparison with the larger classifications, although, interestingly enough, their cultures yielded only coagulase-negative strains.

Table II also summarizes the results of culturing nose and throat swabs from seven family contacts of E.L. Colonies of gram-positive cocci grew on all cultures. Three of the cultures were coagulase-negative strains and four were coagulase-positive. Of the latter, two were of the phage type 44A and two were of the phage type 3A, 3B, 55, 39. None of the strains was antibiotic-resistant nor of the phage pattern carried by E.L. However, occurrence of the two pairs of duplicate strains suggests some communicability among the family members.

The 47 cultures of coagulase-positive staphylococci classified in table II were represented by 12 untypable strains and 24 phage types (35 strains). The first three phage types were represented by four carriers of antibiotic-resistant strains. These are listed in table III, with their types and antibiotic sensitivity patterns given. Table III shows that two persons who carried the antibiotic-resistant strains possessed the so-called 81, or hospital type, a type that has been widely associated with hospital epidemics in this nation and elsewhere. The first person (E.L.) was known to have been a carrier of a resistant strain during her pre-

TABLE II

Classification of Staphylococcal Cultures by Health Center Personnel Examined

Persons Cultured (Nose and Throat)		Gram-Positive Cocci						No Gram-Positive Cocci	
		Coagulase-Positive		Coagulase-Negative		Total			
Classification	No.	No.	%	No.	%	No.	%	No.	%
Public health nursing	50	20*	40.0	17	34.0	37	74.0	13	26.0
Clerical	25	9	36.0	10	40.0	19	76.0	6	24.0
Sanitarian	19	9	47.4	8	42.1	17	89.5	2	10.5
Unclassified	23	9	39.1	9	39.1	18	78.3	5	21.7
Totals	117	47*	40.2	44	37.6	91	77.8	26	22.2
Relatives of E. L.	7	4	57.1	3	42.9	7	100.0	0	0

* Includes 4 cultures of antibiotic-resistant strains.

vious employment in a veterans hospital. The second person (N.C.) had been employed at health center B for approximately one month. She was employed during the preceding months on the pediatrics staff of a large general hospital where the type 81 strain was known to be endemic.

Neither of the remaining two carriers of antibiotic-resistant organisms harbored type 81. One (K.B.), who was a carrier of phage type 7, 47, 53, 54, 73, 75, 77, VA4, also a "hospital type," had been off duty with influenza for five days in April, 1957. Her physician prescribed the antibiotic oleandomycin tetracycline. K.B. had worked in the child health clinic for the past 10 months. The fourth person (R.A.), a carrier of phage type 52, 52A, had worked in the health center's tuberculosis clinic for the past 10 months. She had no history of receiving antibiotic therapy nor of contact with a hospital environment. Of the four carriers of the antibiotic-resistant staphylococci, these last two were the only ones who might have acquired the resistant organism in the course of their health center duties.

Table III also discloses that three of the four antibiotic-resistant strains were resistant to penicillin, streptomycin, chlortetracycline, oxytetracycline, and tetracycline and sensitive to chloramphenicol, erythromycin, and novobiocin. The type 81 strain carried by N.C. was sensitive to streptomycin; otherwise, the antibiotic sensitivity pattern was the same as in the other three strains. The remaining 21 phage types (31 strains) were sensitive to antibiotics and were represented by 15 types with single strains and 6 types with multiple strains (16 strains).

TABLE III

Four Carriers of Antibiotic-Resistant Cultures with Their Phage Types and Antibiotic Sensitivity Patterns

	E.L.	N.C.	R.A.	K.B.
Phage Type	52,42B,81	52,42B,81	52,52A	7,47,53 54,73,75 77,VA4
Sensitivity Patterns				
Penicillin	R	R	R	R
Streptomycin	R	S	R	R
Chlortetracycline	R	R	R	R
Chloramphenicol	S	S	S	S
Oxytetracycline	R	R	R	R
Tetracycline	R	R	R	R
Erythromycin	S	S	S	S
Novobiocin	S	S	S	S

R = resistant; S = sensitive.

TABLE IV

Phage Types Occurring in More Than One Individual

No.	Phage Type	No. Strains	Professions (Center)
1	44A	4	P.H.N. (A) Clinic nurse (A) Sanitarian (A) Typist-clerk (B)
2	7, 77	3	P.H.N. (A) Sr. P.H.N. (B) Typist-clerk (B)
3	6, 7, 47, 54, 75	2	P.H.N. (B) Typist-clerk (B)
4	3B, 3C	2	Caretaker (A) Deputy registrar (A)
5	52, 52A	2	Dairy inspector (B) Sanitarian (B)
6	6, 47, 53, 54, 75, VA4	2	Dairy inspector (A) Sanitarian (B)

Table IV shows the job relationships of persons carrying the six phage types in which multiple strains were found. In five instances persons having similar types worked in the same health center (two instances in center A and three instances in center B). In some of these instances communicability may have been involved, although coincidence could also have played an equal part.

DISCUSSION

One is impressed, on the whole, that so few antibiotic-resistant carriers of staphylococci should be found in a health center employee population of 117 persons. The occurrence of 3.4 per cent resistant carriers is well within the normal range for a nonhospital population. If the carriers of two hospital, type 81 strains, known to have been acquired elsewhere, are disregarded, then, only two resistant strains would be considered as possibly derived from contacts made in the health centers.

One is also impressed with the scant evidence of an exchange of coagulase-positive strains of staphylococci amongst the health center employees. The evidence is also slight

that health center employees acquire potential pathogenic strains of staphylococci from health center patients.

But, how does one account for the fact that carriers of antibiotic-resistant staphylococci were found only among the nursing personnel? Probably because the nurses' duties require closer contact with many persons who, because of recent hospitalization or frequent therapy with antibiotics, may be carriers of the resistant organism. It has been observed that hospital-acquired staphylococci have been transferred to family members after the patient's discharge from the hospital.[7] It is likely that transfer of such strains occurs outside the family circle in some instances.

In what fortunate ways, then, does the health department environment differ from that of a hospital in preventing the problem of antibiotic-resistant staphylococci carriers from developing? First, and most fundamental, the health department does not "treat" patients therapeutically. In a hospital the production of human reservoirs of antibiotic-resistant staphylococci is proportionate to the volume of antibiotic medicaments administered to the patient population.[1] When the use of antibiotics destroys the antibiotic-sensitive staphylococci, the human soil is ready for the implantation of resistant types, and the resistant type or its forerunner is usually on hand in the hospital environment and ready to be implanted.[1] Again, the patients in the health center are ambulatory; most of them are well, and they attend health center clinics for short periods only, usually by appointment. In the hospital, bed patients remain for prolonged periods, and some, suffering from primary or secondary conditions caused by staphylococcal infections, may have discharging lesions. Some are carriers of the resistant organisms, although hospitalized for other reasons. Others, because of lowered resistance from chronic infectious illnesses and degenerative diseases, are susceptible to hospital infections or to acquiring a carrier condition.[2]

Staphylococcal carriers excrete the organisms not only from nose and mouth but in large quantities in the stool. Every means of direct and indirect spread of the organism is possible, but the indirect means is the most common.[8] In the hospital the patients serve as the most important reservoirs for strains of antibiotic-resistant staphylococci.

Finally, health center workers lack contact with the abundant reservoir of antibiotic-resistant staphylococci that hospital attendants encounter daily. Hospital attendants become the most important agents in transmitting the infection because of the high proportion of asymptomatic carriers among them; the nose carrier is the most common, but the throat carrier is the most common, but the throat that some carriers, even without active lesions, can contaminate the atmosphere with much greater numbers of staphylococci than others. Some persons are dangerous even when wearing a sterile gown.[8] The attendant with an active staphylococcal lesion, even as small as a pimple or as "simple" as a slight head cold, should stay off duty. Such persons are especially active carriers. The hands are an important factor in transmitting the organisms from the facial area around the mouth and nose to clothing, gowns, and bedclothes and from these on into the atmosphere. Despite the greatest care, the atmosphere of general hospitals is contaminated with staphylococcal organisms.[8]

Clearly, the hospital picture does not fit the health center circumstances. In comparison, the health center employees are a normal population as far as proneness to staphylococcal infections or carrier conditions are concerned. An occasional carrier of a resistant organism will be found among the group.

The area for special caution in a health center is the place of contact between health center employees and the public, especially in the clinics. A policy for the administrative control of antibiotic-resistant staphylococcal carriers in the health department clinics should be realistic and based on the following facts. First, it must be remembered that an exchange of staphylococcal organisms between the staff members and clinic patients is possible at all times. Second, in the health center setup there is as much risk, if not more, of transmission of potential pathogenic staphylococcal organisms from the carrier-patient to the susceptible attendant as there is from the carrier-attendant to the susceptible patient. Third, the carrier condition is continually shifting its involvement of persons, and everyone carries staphylococci at some time. Studies of cultures obtained from the personnel of the Municipal Disease Hospital in Chicago showed that "over a period of 18 months 75 per cent of the personnel became at least transient carriers of coagulase-positive staphylococci organisms and that two thirds of those persons lost the specific strain within a month. . . . A

few persons lose specific strains slowly and become prolonged carriers." [3]

Obviously, it is impractical to attempt the detection of staphylococcal carriers by frequent culturing, and it is practically impossible to clear up a carrier condition by medical means.[5] Realistic preventive efforts, therefore, should place emphasis on conscientious adherence to nursing techniques, particularly those of hand-washing. In addition, a nurse with pustular lesions or with an acute respiratory infection should stay off duty until recovered.

SUMMARY AND CONCLUSIONS

The rate of coagulase-positive staphylococcal carriers in a health center population of 117 persons was 40.2 per cent, which is comparable to rates found in a normal population. The rate of carriers of antibiotic-resistant staphylococci found in the health center population was 3.4 per cent. The carriers of resistant strains were members of the nursing staff and composed 8 per cent of that group. Both rates are within ranges reportedly found in normal populations.

The communicability of staphylococci among family members was illustrated by the cultures obtained from seven family contacts of E.L., a public health nurse. Among health center personnel there was no evidence of exchange of antibiotic-resistant strains and slight evidence of the exchange of other potential pathogenic strains of staphylococci. Between the health center personnel and the health center clinic patrons there was a possibility of the transfer of antibiotic-resistant organisms.

In the two health centers surveyed, the environment was not favorable to the emergence of resistant strains nor to the transmission of these or other potential pathogenic strains.

Administrative measures to control the spread of antibiotic-resistant staphylococci should emphasize the observance of good nursing, housekeeping, and aseptic techniques in the clinics, with emphasis on hand-washing and the exclusion of persons with pustular lesions and respiratory infections.

ACKNOWLEDGMENT

The author wishes to thank Mr. C. C. Carson, epidemiologist assistant, for his valuable aid in planning and guiding the study; Carl A. Lawrence, Ph.D., bacteriologist, for his cooperation, advice, and technical laboratory assistance; District Health Officers P. R. Auriemma, M.D., and Harry B. Silver, M.D., for their helpfulness in securing specimens; and Miss Elizabeth Casper, P.H.N., E.I.S., for her patient assistance. The author also is indebted to the health department staff members who volunteered as subjects in the study. Especially valued is the help of Jean Dedrick, Ph.D., microbiologist, Los Angeles County General Hospital, Communicable Disease Unit, who performed the phage typing required in this study.

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Encephalitis

Evelynne G. Knouf, M.D.

ENCEPHALITIS IS A DISEASE entity unfamiliar to the average physician. Physicians in general are not interested in learning about sleeping sickness because they feel that it is a medical oddity and really a problem for an epidemiologist, for one who investigates outbreaks of arthropod-borne viral encephalitis, or for the neurologist who inherits the survivors of certain epidemics. Very few in medicine appreciate that postinfectious encephalitis is one of the most common of the acute neuropathies, at some time a complicating factor in any or all viral and bacterial infections.

Postinfectious encephalitis occurs frequently after the childhood diseases, such as measles, chicken pox, and mumps, and it may be a complication as well of the common cold, poliomyelitis, pertussis, infectious mononucleosis, the dysenteries, and the meningitides. As a member of the medical staff of the Communicable Disease Unit of the Los Angeles County Hospital since 1940, I have seen numerous patients develop postinfectious encephalitis after every infectious and contagious disease except typhoid fever. Although the Communicable Disease Unit admits and treats an average of 30 patients with typhoid fever yearly, not 1 case of encephalitis was seen as a complication of this infection during the last 17 years. The encephalitis associated with typhoid fever, occasionally referred to in medical literature, represents a phase of overwhelming toxemia called the typhoid state, the manifestations of which are coma vigil, carphologia, subsultus tendinum, and muttering delirium. The "typhoid state" may occur in any bacterial disease when toxemia is exaggerated. In our experience the patient with typhoid fever either recovers completely or dies in this state. However, in all other diseases the survivor of the typhoid state frequently is left with some postencephalitic complications.

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SIGNS AND SYMPTOMS

Encephalitis as a complication in any acute infection is usually recognized by change in the sensorium of the patient. That change may be characterized by varying degrees of lethargy or coma, or by agitation, as seen in those who are hyperirritable, irrational, maniacal, or psychotic. All reveal deviation from the normal personality. To the cerebral signs may be added meningeal irritation, as shown by stiffness of the neck or back. Some degree of myelitis with weakness and paralysis is common. Occasionally bulbar involvement as evidenced by cranial nerve paralysis may be seen. In establishing the correct diagnosis one is aided by obtaining a diffusely abnormal electroencephalogram. The peripheral white blood cell count usually is elevated and the spinal fluid cells average between 25 and 500 white blood cells per cubic millimeter, mostly lymphocytes. Rarely one may examine a spinal fluid that has either no cells or more than 1,000 per cubic millimeter.

In the Communicable Disease Unit during the 12 year period between 1940 and 1952, encephalitis was diagnosed in 215 of a total of 2,967 cases of measles. There were 13 deaths, of which 7 occurred less than 24 hours after hospital admittance. Of the patients with encephalitis, 100 had electroencephalograms made and 68 per cent of these tracings were abnormal. Also, 40 per cent had a generalized convulsion at the onset or early in the course of the encephalitis; 76 per cent had a fever of 101 F or more; 53 per cent had meningeal signs; 9 per cent had bulbar involvement; 6.9 per cent had weakness or paralysis of one or

more extremities; and 8.9 per cent demonstrated athetoid or choreiform tremors. Reflexes were normal in 58 per cent of the cases and headache was a prominent complaint in only 5.5 per cent. Regarding mental status, 46 per cent were lethargic, sleepy, or drowsy; 35 per cent were deeply comatose; 16 per cent were conscious, but irritable, irrational, incoherent, agitated, and hallucinating; and 1.4 per cent had a clear sensorium and demonstrated only meningeal signs.

TREATMENT

The usual recommendation for the therapy of encephalitis in the acute stage is symptomatic and expectant. Yet, the patient who does not spontaneously recover and who remains in a vegetative state is a potential candidate for a mental institution unless death from secondary infection intervenes. In the Communicable Disease Unit of the Los Angeles County Hospital the patient with encephalitis who remains vegetative, regardless of etiology, is treated with typhoid vaccine if the relatives permit. This form of therapy was initiated in the County Hospital by the chief physician of the Communicable Disease Unit in 1924. Prior to 1940, the patients usually were given not more than three or four intravenous injections of typhoid vaccine; if there was no response, further treatment was considered useless. However, enough patients did respond to make it seem desirable to try this therapy in any case of encephalitis not clearing spontaneously. On my service during the last 17 years the therapy with typhoid vaccine has gradually evolved until now we have a routine that makes treatment safe: 1. Shock, formerly formidable, is anticipated and prevented.[1] 2. We no longer stop with three or four injections but pursue treatments to the maximum limit for improvement (these may exceed 100). 3. The patient is not considered cured, although appearing to be clinically normal, until the electroencephalogram has become normal and remains so during a challenge with typhoid vaccine.

Initially, the vaccine used was that ordinarily used for routine immunizing purposes, a combination of typhoid and paratyphoid organisms. However, greater success with typhoid vaccine has been obtained since using freshly prepared vaccine that has been made for us by our own laboratory during the last five years. Also, we have been successful in administering vaccine intramuscularly and have been able to treat many more patients at the same time, since Parke, Davis and Company in 1955 provided us with a highly concentrated typhoid vaccine containing 100 billion organisms per cubic centimeter.

COMMENT

The use of typhoid vaccine in medicine is not new. It is only one of many products used for shock or fever therapy in the treatment of neurosyphilis, arthritis, iritis, and many other disease conditions. In these, as in encephalitis, typhoid vaccine was used to produce fever of high degree. However, we feel that hyperpyrexia is not the curative factor. The reticuloendothelial system is stimulated, as evidenced by the rapid change of the white blood cell count during therapy and also by the increasing Widal titer. Possibly, the entire action of typhoid vaccine may be explained upon the basis of changes in cellular permeability and stimulation of the immunity mechanism within the reticuloendothelial system. Or perhaps the vaccine puts into action some enzymatic process that in turn prompts the nerve cells, which are temporarily unbalanced chemically, to return to a normal state of equilibrium.

While studying the hundreds of treated and untreated cases of postinfectious encephalitis, many observations have been made. During the last five years a constant finding in the severe or chronic encephalitic patient is that sterile urine cultures repeatedly show growth of *Staphylococcus*, *Streptococcus*, or *Escherichia coli*. In addition, the patients with positive urine cultures frequently maintain tremendously elevated sedimentation rates despite the fact that pus is often absent, that the temperature is continuously normal, and that the peripheral white blood cell count is within normal range. Another interesting finding in the encephalitic patient is that the majority give laboratory evidence of thyroid insufficiency. I do not believe that this is a result of the brain injury incurred with the encephalitis, but rather that this insufficiency was present previous to the infection, and, in such individuals, may have played a part in predisposing to encephalitis. The brain is not the only tissue in the body that may be cheated or poorly constructed in the growing child, whose inadequate metabolism also may be manifested by slow skeletal growth, delayed

dentition, emotional immaturity, and a poorly functioning reticuloendothelial system, one that repeatedly fails to function with even minor infections. For a number of years I have been impressed with the similarity of the signs and symptoms in the child with poor or inadequate thyroid metabolism and of those of the postencephalitic patient. Both usually are behavior problems and do poorly in school, chiefly because they cannot concentrate, tend to have poor muscular co-ordination, have emotional outbursts exhibited as temper tantrums, become easily frustrated, worry excessively over insignificant happenings, and tend to magnify situations; many times they are so abnormal in their behavior pattern as to make it obvious to parent and teacher that they approach psychosis. In general, hypothyroid and postencephalitic patients are unequal to the task of living and unable to cope with their environment. In adult life they may be mentally retarded, emotionally delinquent, psychoneurotic, or eccentric, with antisocial or criminal behavior. Laboratory data, now being collected and analyzed preparatory to publication, will help later to clarify the ideas recorded here.

SUMMARY AND CONCLUSIONS

This brief paper on a large subject will serve its purpose if it stimulates physicians to a more careful evaluation of all patients, helping them to remember that behavior problems of childhood should be investigated with endocrine deficiency and encephalitis in mind. Also, it is suggested that it might be well to investigate in similar fashion the juvenile delinquent, the psychoneurotic, or the eccentric or obstreperous adult. There is the possibility of unrecognized encephalitis having occurred after one of the childhood infections. In fact, the day may not be too far distant when we will consider it wise and important to do routine electroencephalograms on all school children, hospital patients, and mentally and emotionally disturbed persons, just as we do routine chest roentgenography for the detection of tuberculosis. In the Communicable Disease Unit of the Los Angeles County Hospital, we have taken a step in this direction. In the five year period since 1952, we have attempted to do routine electroencephalographic tracings on all patients with contagious diseases. The valuable information elicited from that study will be published in the future.

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Guest Editor

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Her avocations are art, orchid growing, incunabula, and foreign travel.

Epileptic Seizures Differentiated from Cardiovascular Syncope and Functional Episodes

Elinor R. Ives, M.D.

THE PHYSICIAN OCCASIONALLY is vexed by the problem of whether a patient's episodes are due to epilepsy, syncope, or hysteria. In the differential diagnosis certain facts should be considered.

Epilepsy is a general term denoting seizures caused by organic disease of the brain. From the pathological standpoint, it is a condition characterized by aberrant discharges of electricity in the cerebrum. Seizures are a manifestation of the aberrant discharge and may be produced by any pathological process provoking such a discharge. Epilepsy, therefore, is not a disease entity with a specific etiology. It is instead a category including numerous diseases and pathological states which may have only one feature in common; that is, that they evoke repeated bursts of cerebral dysrhythmia.

From the clinical standpoint epilepsy may be defined as a chronically recurring disturbance of consciousness. "Chronically recurring" indicates that the diagnosis cannot be made until the patient has had several episodes. "Disturbance of consciousness" implies one cardinal point in differentiation: The epileptic has no recollection of his attack. He is completely unaware afterward of what occurred at the time of the seizure. The single exception to this may be the patient with a superficial cortical lesion who suffers jacksonian seizures. If the exciting pathological discharge is sufficiently small, and the lesion sufficiently limited in the cortex, the patient may experience brief motor or sensory phenomena and still be in touch with his environment. Whether grand mal or minor, the epileptic seizure due to an abnormal cerebral discharge is always of short duration. The actual grand mal convulsion itself, even when severe, is short. Patients may sleep for 24 hours afterward, or may have repeated seizures in succession over a prolonged period of time, but each individual seizure passes rapidly. Episodes usually last less than 5 minutes, never over 15 minutes.

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Psychomotor seizures are exceptional. While having these seizures, patients continue walking and talking, apparently in conscious control, but later have no memory of what happened for a matter of hours. These patients form a borderline group merging with the hysterias. It is hard to distinguish patients with true cerebral dysrhythmia from those with hysterical fugue. The diagnosis is made by factors other than a description of the seizures.

Epileptic seizures vary enormously. The term "disturbance of consciousness" embraces an immense display of seizure patterns that do not resemble the classical grand mal, psychomotor, or petit mal seizures described in the textbooks. Generally, the seizures experienced by any one patient tend to be similar. However, anticonvulsant medicaments and the passage of time tend to modify seizures to different abortive forms. The untreated patient usually has severe episodes characterized by rigidity, falling, and some type of clonic or tonic movement. Treated patients and those with mild forms of epilepsy may or may not convulse, fall, or move. Movements, if made, may be rhythmic, random, or more or less purposeful. One of my patients yawns; another fumbles at his clothes. In another, the left arm is rotated and drawn backward. Another mumbles indistinguishably. Still another tinkers with his pen knife and may cut at random with it. In most instances the patient appears preoccupied or abnormal. Relatives state, "He looks queer—glassy-eyed." Unless comatose, many patients resist interference. It is well to let them alone.

DIFFERENTIATION FROM CARDIOVASCULAR SYNCOPE

Cardiovascular syncope is essentially a vasomotor collapse. The patient is in temporary shock. The pulse at onset is absent or thready. The patient appears pale and perspires profusely. He feels clammy to the touch and "in a cold sweat."

In cerebral dysrhythmia seizures may be manifested by vasomotor disturbance, but the patient does not exhibit shock. He may be pale, cyanotic, or red. He may feel hot and damp or cool and dry, but he never feels cool and damp. The pulse in organic seizures is usually normal, but after a convulsion it may be full and bounding, due to the physical exertion of the convulsion.

Syncope never occurs when a patient is lying down, and rarely when the patient is sitting. Epileptic seizures occur regardless of the position of the patient. Syncope may be warded off by the patient sitting with his head bent over between his knees. Epileptic attacks occasionally can be "fought off" but not by positioning. On the contrary, patients find that certain types of physical activity may inhibit the attack.

Syncope may be preceded by a sensation of nausea or of "things going black," but never by the visual, olfactory, sensory, or motor aura rather commonly found in epilepsy. However, both in syncope and epilepsy the patient may pass out without warning.

In syncope the patient sinks to the ground comparatively gently. There is a collapse: The knees flex and the body crumples forward, somewhat as a rag doll might. In epilepsy the fall may resemble the slumping of syncope, but much more often the patient falls hard. The body stiffens and goes over forward, backward, or to the side, with the forcible impact of a statue suddenly upset. In syncope muscle tone is decreased; in epilepsy muscle tone is usually increased during the seizure. The patient in syncope never convulses, never stiffens, never bites his tongue or lips, never hurts himself, and never urinates or defecates. The epileptic during a major seizure frequently does one or all of these; however, during a mild seizure, he may not.

After a syncopal attack the patient may feel nauseated, weak, or "faint," but not drowsy. The majority of epileptic seizures are followed by a sensation of drowsiness if not by actual slumber. Patients may be weak or sore but are rarely "faint." Headache can accompany or follow either epileptic or cardiovascular episodes and therefore is not a differential feature.

Epilepsy and cardiovascular disease merge in two syndromes: carotid sinus irritability and the Stokes-Adams syndrome.

The carotid sinus lies at the bifurcation of the common carotid artery in the neck. Pressure, as by a tight collar, or sharp movements in flexion or lateral rotation of the head, stimulates the hypersensitive sinus, producing bradycardia, transient cardiac arrest, and/or drop in blood pressure. The patient abruptly loses consciousness. In these cases the seizure tends to be akinetic rather than convulsive. Patients recover quickly and without drowsiness. Diagnosis depends on the history that the seizures are produced by quick movements of the head and by corroborative electrocardiographic tracings.

In the Stokes-Adams syndrome the seizures are due to cerebral ischemia engendered by intermittent interruption of the cardiac rhythm. The patient usually has advanced cardiac pathology, and the electrocardiogram shows auriculoventricular block.

DIFFERENTIATION FROM FUNCTIONAL SEIZURES

Neurotic and psychoneurotic patients often display erratic episodes or conversion reactions, which must be distinguished from true epilepsy. Functional seizures never occur when the patient is alone or when it is inconvenient for the patient to have one. They are always incident to a frustration, to a desire for attention or gain, or to other environmental circumstances.

Epileptic seizures occur at any time. They are often precipitated by emotional stress, but they are not limited to such occasions. The patient may be alone, in the center of a family argument, or enjoying a fishing trip.

Neurotics and psychoneurotics know what is going on during an attack. Epileptics do not. Functional seizures usually last over 15 minutes; organic ones do not. The hysterical episode terminates either gradually or rapidly into happy normalcy if the patient gets his way. Organic seizures are often followed by drowsiness. The patient may sleep for one-half hour or more. Both neurotics and epileptics may feel a relief from tension after an attack.

The patient with functional seizures falls softly, never hurts or burns himself, does not

bite his tongue, and does not urinate or defecate during a seizure. The epileptic may not either. The absence of a hard fall or other criteria does not rule out epilepsy, but the presence of any of the above excludes a strictly functional etiology.

The stupor or coma following an organic seizure can be differentiated from the simulated coma of the psychoneurotic by examining the patient. A positive Babinski sign is proof of cerebral disease. The patient with functional seizures never shows objective neurological findings. The unconscious epileptic lies with eyes open or closed and makes no resistance in the latter instance when the examiner raises the eyelid. The patient with functional seizures lies usually with eyes closed and definitely resists raising of the eyelid.

The patient's past performance must be considered in arriving at a diagnosis. Persons with a good work record and no previous apparent personality disturbance do not develop functional seizures in middle life. The converse, however, does not hold true. A psychoneurotic individual may at any time develop a brain tumor or other organic lesion that can cause epilepsy. The differential diagnosis in these cases is difficult. In general, functional seizures must be precipitated by some emotionally disturbing experience. The patient rarely volunteers the experience or admits a correlation. The physician, therefore, must elicit an adequate personal history with dates. Correlation of seizures with emotional stress favors a diagnosis of functional illness but does not prove it. The physician must be on guard to detect underlying organic pathology. Certain organic entities may be manifested by aberrant behavior and epilepsy. In such cases the personality disturbance is the result of disease not the cause of it.

Tumors of the frontal lobe produce a gradually progressive personality change, occasionally with epilepsy. Patients may appear deteriorated, psychoneurotic, or psychotic. If the tumor is benign and slow-growing, the neurological examination often is completely negative. Seizures in these cases may be hysterical, organic, or a combination of both.

Chronic alcoholism is both a manifestation of personality disturbance and a cause of organic disease of the brain. Alcoholics may develop mental deterioration and epilepsy as a consequence of the intoxication and avitaminosis per se, or as a result of cerebral contusion from head injury. Rarely, are symptoms due to interval hemorrhage, but, if so, the person is in critical need of surgery.

Syphilis, either meningovascular or general paresis, may be manifested first by aberrant behavior. All patients revealing an apparent change of character in middle life should have at least one or two Wassermann tests of the blood and possibly one of the spinal fluid. Similarly, all patients experiencing the first seizure in middle life should be examined for syphilis. In cases where the pathological changes are limited primarily to the prefrontal areas of the brain, patients may exhibit both hysteria and organic seizures, but little else.

Less frequently encountered but treacherous when present is hypoglycemia, or so-called idiopathic hyperinsulinism. Patients complain of weakness, fatigue, confusion, irritability, and rarely hallucinations. Relatives complain that it has become impossible to get along with the patient. Seizures are usually psychomotor and vary from random activity to maniacal states. Theoretically the hypoglycemia should be demonstrated by a five hour glucose tolerance test, but often it is not. In suspicious cases the test should be repeated and, as a last resort, blood samples drawn during a 24 hour period of fasting.

Concussion or contusion of the brain can initiate a progressive atrophy of one or more parts of the cerebrum. If the atrophy involves the frontal lobes, the patient becomes deteriorated and may evidence psychoneurotic behavior. The diagnosis of head injury, however, is usually given to the physician by both patient and relative. Hypothyroidism and certain degenerative diseases produce the same picture. The patient and relatives are no help here. The physician must rely upon laboratory procedures.

SUMMARY AND CONCLUSIONS

The differentiation of seizures into the epileptic, cardiovascular, or functional type is only the beginning of the problem. Epilepsy is a symptom found in innumerable organic diseases of the brain. The physician cannot rest with just a diagnosis of the symptom—he must discover the cause of the disease. Similarly, syncope and functional seizures present the same challenge: the one in cardiovascular pathology, the other in the psychodynamic mechanisms responsible for the patient's state. The range of diagnoses within each category is a wide one and far beyond the scope of this paper.

Maternal and Child Health Program in the Los Angeles County Health Department

Beryl S. Graham, M.D., M.P.H., and Roy O. Gilbert, M.D.

THE LOS ANGELES COUNTY Health Department serves a population of approximately 2.7 million people in 55 cities and the unincorporated area of the County. The Bureau of Maternal and Child Health includes the divisions of maternal health, child health, public health dentistry, and public health nutrition. Administrative personnel of the Bureau are the director and assistant director of maternal and child health, a senior public health physician, a chief public health dentist, and a chief public health nutritionist. Three public health nursing consultants act as a liaison between this Bureau and the Bureau of Public Health Nursing.

Objectives in maternal and child health include the promotion of high standards of care during pregnancy, the prevention of prematurity, and the improvement of care of the infant and the mother in hospitals, as well as after their return home. As the child grows, he should have the benefits of affectionate family support, a sanitary environment, good nutrition, regular health supervision (including protection from preventable disease), good medical and dental care, and education in safe and healthful ways of living.

To attain these objectives, this Bureau has, during the past year (1956-1957) done the following:

1. Conducted 1,403 prenatal conference sessions at 27 locations throughout the County where pregnant women who could not afford private care received prenatal supervision. A total of 22,026 visits were made by 5,789 women.
2. Held 4,412 child health conferences in 75 locations. A total of 94,523 visits were made by 28,419 children under the age of 2 years, who were not under private care for well-child supervision. They were given regular physical examinations and the usual immunizations. Problems relating to growth, development, and normal behavior were discussed with their parents. Referrals were made to their usual source of medical care when any condition requiring medical treatment was discovered.
3. Conducted 182 rheumatic fever diagnostic clinic sessions in two locations. Private physicians and school personnel referred 493 children for suspected rheumatic fever. The confirmation of this diagnosis, followed by referral for treatment and continued care, or the removal of the suspicion of the disease, is the objective of this service.
4. Provided medical consultation for: (A) the classes conducted by public health nurses for expectant parents (these classes, in 27 locations, were held for patients of prenatal conferences and of private physicians); (B) staffs of maternity hospitals regarding standards of care for mothers and infants, with particular emphasis on the current, burgeoning problem of the control of antibiotic-resistant staphylococcal infections; (C) the parochial school health program, through which public health nurses provide demonstrations, assistance in planning, and consultation to these schools on the request of the school administrator; and for (D) a class given every six weeks on

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"Emergency Childbirth" to new recruits of the sheriff's department (in 1956 the sheriff's office received an average of 52 calls per month on emergency deliveries and succeeded in getting most of the mothers to the hospital in time). All four of these activities were done in conjunction with a maternal and child health nursing consultant.

5. Conducted parent discussion groups in two locations. This has been done as a pilot study to evaluate this type of service to parents of infants and preschool children and is being extended to a third location this year.
6. Co-operated with the University of Southern California and the University of California at Los Angeles in training programs in which medical students and residents, as well as students of nursing, medical social work, nutrition, and psychology, observed or participated at prenatal and child health conferences. It is felt that this is an opportunity for stimulation of our own staff, as well as for training future health personnel in maternal and child health supervision.
7. Explored the possibility of developing perinatal mortality study committees in maternity hospitals and made statistical studies to determine conditions and needs of various areas of the County. These will be available to physicians in these hospitals.
8. Prepared a questionnaire designed to show financial, educational, and other characteristics of parents who attend child health conferences. This was done to assist in establishing priorities for attendance at the conferences. Questionnaires returned by 3,341 parents during a two week period indicated, in general, that these parents would not otherwise obtain such a service.
9. Co-operated in a research project of the College of Medical Evangelists by performing "wet diaper" tests for phenylpyruvic acid at each visit of all infants under the age of 1 year at child health conferences. It is hoped that early detection of phenylketonuria, followed by use of a phenylalanine-restricted diet, may prevent mental deterioration of such infants.
10. Provided medical consultation for a weekly television program, entitled "Your Baby and You," on which questions that were submitted by mothers were discussed.
11. Through the dental health division offered service in 16 locations, with emphasis upon prevention of dental disease by means of health education and prophylactic care. Corrective care is given to those children whose parents cannot afford private care and to patients registered in prenatal conferences. Two dental hygienists examine the teeth of school children, encourage their interest in dental hygiene and proper diet, and inform parents of needed care. Frequent discussions on the subject of fluoridation and other aspects of dental health are conducted with various community groups.
12. Promoted knowledge of good nutrition through the division of public health nutrition, which is a valuable source of information to members of the Health Department staff, and through them to the clients they serve. A comprehensive study of food costs has recently been made to assist low-income families in the selection of nutritionally adequate foods within the limits of a given budget. Consultation in nutrition education is available to the schools and community organizations.

Currently being pursued is the study of the trend of maternal, perinatal, and infant mortality rates, since this is one tangible method of determining program emphasis and needs. Of 67,693 live births in 1956, 22 maternal deaths occurred among residents of our jurisdiction, with a maternal mortality rate of 0.3 per thousand live births, as compared with 0.4 in 1955. The perinatal mortality rate, however, advanced from 28.4 in 1955 to 29.0 in 1956. More significantly, the infant mortality rate reversed the downward trend that had been experienced until 1954, at which time it was 21.0 per thousand live births. A small increase to 21.6 occurred in 1955, and the rate rose to 24.0 in 1956. Several hypotheses have been put forth to explain this rise, among which is the occurrence of staphylococcal infections present in many hospital nurseries. Detailed studies have not been completed, but statistics presently available indicate that the causes of the additional deaths were divided about equally between infections of the respiratory system and noninfectious conditions associated with

prematurity. Further study of the types of respiratory infections and of the care given premature infants, especially the possibility of oxygen withheld because of awareness of its relation to retrolental fibroplasia, should give us more specific information.

While these activities are being continued, it is planned to revise them as seems necessary to conform with the changing needs of our people. The protection and promotion of the health of mothers and children are influenced by so many factors that success must involve many different ways of approaching problems. Considering the ever-present limitations of time, effort, and money, emphasis must be placed on procedures from which some success may be anticipated. Attention will be directed toward the particular groups that epidemiologic studies have shown are making disproportionately large contributions to the total amount of ill health and death in the community.

Law Drafted to Cut Poison Deaths

After a 15 month study, the Committee on Toxicology of the American Medical Association announced on Jan. 29 that it has formulated a broad and encompassing model law for the precautionary labeling of hazardous substances in commercial, household, and industrial chemical products. The law is directed against those hazardous substances defined as toxic, irritating, sensitizing, corrosive, flammable, explosive, or radioactive under customary or reasonably anticipated conditions of handling and use.

The law, as drafted by the AMA Committee, headed by Dr. Torald Sollman of Cleveland, would: (1) require the labeling of all chemical products containing hazardous substances that are not now regulated; (2) require the same labeling standards to apply to chemicals for export as those for domestic consumption, thereby obviating the common complaint that less-than-standard products are sold to foreign customers; (3) prohibit re-use of food and drug containers bearing their original labels; and (4) require identification and warnings for strongly sensitizing chemicals that cause allergic or inflammatory reactions in living tissue on contact.

The Committee's work had strong support not only from the chemical industry but also from the National Drug Trade Conference and the American Public Health Association. "Lack of information about hazardous ingredients in certain emergencies," Bernard E. Conley, Ph.D., and Secretary of the Committee, said, "may enhance the gravity by complicating or delaying treatment." He also stated that latest mortality statistics show that 1,431 persons died from accidental overexposure to packaged chemicals in 1955. "One quarter of these fatal accidental poisonings by liquid and solid substances occurred in children of preschool age and over 80 per cent occurred in the home. Nonfatal poisonings are estimated to be 100 to 150 times the number of fatalities." He added, "And these are impressive statistics for a cause of injury and death that is considered to be largely preventable."

While children are the most frequent victims, the fault of negligence does not necessarily rest at the doorstep of the parents, Dr. Conley said. "Most of the children who take poison are active and curious, and most of the substances ingested by them are easily accessible. Even the parents failed to realize that a number of common household substances were poisonous until after the accident occurred. The model law will help parents become more aware of the hazards and thereby reduce fatalities."

Physician on the Witness Stand

Wendy Stewart, LL.B., M.D.

WITH OUR SURGING VOLUME of litigation, especially of personal injury actions, physicians today face an ever-increasing number of court appearances. Aside from the time and general inconvenience involved, the physician who appears as a witness commonly experiences a sense of frustration. Physicians often complain that they felt thwarted by the courtroom procedures in their efforts to present their testimony and that the findings of judge and jury were contrary to established medical opinion.

The aim of this article will be to present practical suggestions, based upon the writer's observations in the trial of actual cases, that may be of real and immediate value to physicians. The specific problems to be dealt with have been selected from those that, in practice, are frequent causes of difficulty, but that have been little discussed elsewhere.

Let us consider first the physician in the regular routine of medical practice, far in advance of the time at which the necessity arises of appearing in court. He may see large numbers of patients daily, many of them manifesting symptoms and physical signs that are somewhat similar. Usually, of course, written records are kept—either notations made by the physician personally or records produced by dictation to an office nurse, medical secretary, or recording machine, with subsequent transcription. These routine medical records, so important in the care of the patient and in estimating the progress of any observed condition, may be even more important, for they may be crucial to the outcome in a lawsuit. Whether in future litigation they will be of the maximum value, quite valueless, or perhaps even positively detrimental depends upon whether they comply with certain standards at the time they are made.

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It may be difficult for the physician when called upon in a legal action months, even years, later to recall exactly what was observed and what conclusions were drawn. It is perfectly natural to want to rely upon the routine medical records. There is in fact some danger in claiming independent memory of those observations and conclusions. Skillful cross-examination may implant in the minds of a jury the question, "Would it be likely that this physician would actually remember all the details of one among many medical examinations made so far in the past, especially since there was no particular reason at that time to expect they would come up in this lawsuit?" On the other hand, the physician may be courting danger by admitting that the details are no longer clearly remembered and attempting to rely entirely on the written record. Unless the record when made was consciously designed to conform to certain legal rules, it is quite unlikely that it can be used as evidence.

There is a legal doctrine of "past recollection recorded" that allows a witness who does not actually retain in mind a recollection of details to use a written record in giving evidence, provided it complies with certain quite specific requirements. The exact wording of the applicable rules of legal procedure varies somewhat in the different states, but the provisions are in substance rather similar.

First, the record must have been made by the person appearing as a witness, or by someone else at that person's direction (thus allowing for the production of the record by processes of dictation and transcription).

Second, the witness must be able to state that the written record was correct; that is, that the witness knows it was true at the time it was made.

Third, the record must have been made at a time when the observations recorded were fresh in the memory of the witness, preferably at the time those observations were made, or immediately afterward.

Judge and jury will obviously have greater confidence in details recorded before likelihood of litigation developed than in what a physician, when summoned to the witness stand in an actual lawsuit, may claim to remember having observed. Hence the desirability of completing records of examinations promptly and of including notations that will verify their accuracy as well as the time at which they were completed.

It is recommended that a record of the findings upon physical examination of a patient include: (1) the date and time of the examination; (2) the date and time at which the record was written by the physician, or the time at which it was dictated and transcribed; (3) the initials of the physician identifying anything the physician has personally written; (4) the initials of anyone to whom any part of it was dictated, or a notation that it was dictated to a recording machine; (5) the initials of anyone who has done the work of transcription; and (6) the physician's initials, at the end of the record of that particular examination, following a specific notation showing the date and time at which the physician read over the completed record and indicating that it is approved as being correct.

Certainly the physician should read over each such record within a short time after the examination of the patient. Especially is this to be urged if it has passed through the process of transcription. Under no circumstances should approval be noted where the record contains a statement of anything, even of seemingly minor importance, that the physician is not sure of actually having observed. It is tempting to medical secretaries, perhaps even more than to physicians themselves, to try to get down on paper all the details of a complete examination, especially when using a printed form with blank spaces provided for the reporting of all of the observations customarily made. Consider, however, the unhappy plight of a certain physician about to appear as a witness for the defendant in a personal injury action. The defendant's attorney brought to his attention the fact that the written record of his examination of the plaintiff indicated by the usual "20/20" that she had normal vision in both eyes, while the records of other physicians who had examined her were unanimous in indicating that for many years previous she had a glass eye. True, in that particular lawsuit the plaintiff's vision was not an essential issue. But one can well imagine how much cross-examining legal counsel could make of this error, throwing doubt upon the physician's competence, thoroughness, and accuracy. The obvious results would be embarrassment for the individual physician, detriment to the cause of the party in whose behalf he was called as a witness, and impairment of the prestige of the medical profession as a whole.

Hence the recommendation that written records, especially those made by someone else at the physician's direction, be very carefully checked to make sure they represent correctly what was observed. If definite recollection about any particular symptom or physical sign is lacking, the entry made should be, "Not noted at this examination." This should be later supplemented by a duly dated note of the missing detail, itself complying exactly with the afore-mentioned requirements, added at the earliest opportunity to make an acual observation.

Let us now consider the physician who is about to be called as a witness in a pending lawsuit. Very commonly inadequate time is given to the preparation of medical evidence in advance. This is in part because physicians are such extremely busy persons but doubtless is also due to the fact that physicians do not know just what should be included in such preparation.

The physician should certainly aid in formulating the questions to be asked by the attorney for the party in whose behalf the court appearance is to be made. These must be so planned as to elicit from the physician answers that will present accurately and in logical sequence the medical facts and opinions which the attorney desires to place in evidence.

It is a good idea for the physician to read the relevant portions of some of the books on legal medicine commonly available to attorneys in the locality. If these are not in an easily accessible medical library, perhaps the attorney will arrange for the physician to read them in the local law library, or will lend copies from his office shelves. The physician should discuss these books on legal medicine with the attorney and should also make available to him the text of any medical books or

articles that might be expected to help a lawyer in understanding and presenting the medical aspects of the case. Physician and attorney must discuss the medical testimony thoroughly if it is to go forward smoothly and achieve its maximum potential.

To that end, the physician needs also to know something of the rules of evidence that will govern the proceedings in the courtroom. An illuminating book on this topic is "So You Are Going to Be a Witness," by Alexander Rose. Excellent and highly entertaining, this volume is now out of print; but, it is available at many libraries as part of their permanent collection or, upon request, can be obtained by them through reciprocal book-borrowing facilities. Another book of considerable merit for the prospective witness is "Laugh at the Lawyer Who Cross-Examines You," by James Cusumano.

An important phase of the physician's preparation to testify is the careful selection of the actual words to be used in describing what was observed and in stating the resulting conclusions. The obligation of a witness to tell the truth goes beyond merely telling it, being properly fulfilled only if that witness succeeds in conveying the truth, that is, in telling it understandably. Language that would come naturally to a physician and convey a clear picture to another physician must be translated into words that will conjure up a reasonably correct picture in the minds of judge and jury. They, although usually persons of comparatively little scientific training, must reach a decision based in large part upon what they think the witness said. Physicians appearing on opposing sides of a case obviously will state opinions that are contradictory in important respects. The tendency is for judge and jury to favor the views expressed by witnesses they can understand, even where as a matter of scientific fact and justice those of the witnesses on the other side should have prevailed.

Preparation for the court appearance should in some cases include the making of diagrams or charts of blackboard size so that judge and jury can readily see them. Alternatively the physician might plan on requesting the use of a blackboard and making an explanatory diagram in the course of giving testimony.

Frequently a physician's evidence makes an insufficient impression because general and inclusive phrases are employed where it would be better to spell out the details. What physician, for example, upon observing that an inflammatory process is present, consciously enumerates those five separate cardinal phenomena that Celsus as far back as the first century A.D. summarized as "*calor*, *rubor*, *dolor*, tumor, and *et functio laesa?*" When appearing in behalf of the plaintiff in a personal injury suit, the physician customarily testifies merely that a particular part of the body was examined and that "it was inflamed." This falls short of doing justice to the plaintiff's cause. The physician's function as a witness is better carried out by a clear and separate statement of each of those individual phenomena. The witness might say, for example, that the part when examined was "very red and swollen and felt hot to the touch" and that "the patient evidenced pain and had an abnormal gait in walking" (or other appropriate sign of impaired function). If the physician feels impelled in such a case to refer specifically to inflammation, this impulse is best satisfied by first drawing the picture in detail, as outlined, and then adding that the particular part of the body "was extremely inflamed" (or "moderately," or "slightly," as the condition would warrant). Breaking down the idea of inflammation into its component parts does more than enable the physician to convey in general a clearer picture to judge and jury. It offers the opportunity to depict what was observed more accurately by specifying varying degrees of heat, redness, swelling, pain, and impairment of function.

A physician's evidence usually consists of statements both of facts observed and of opinions formed. Statements of opinion should of course be made as definite and positive as is conscientiously possible. At the same time, the manifest desire of an expert witness to avoid a show of positiveness not warranted by the circumstances may be highly effective. I well remember a personal injury action in which the plaintiff claimed she had suffered a miscarriage resulting from the impact between the car in which she was riding and an improperly fastened gas meter that had fallen from a gas company truck into the street. Several physicians had already testified with much positiveness in her behalf without apparently making much of an impression upon the judge. The testimony of the last of her medical witnesses was by contrast remarkable because of the restrained nature of his answers.

"Could you say," queried the plaintiff's at-

torney, "that an injury of the kind described would cause a miscarriage?"

"No," replied this witness (to the momentary discomfiture of examining counsel), "I couldn't say that it would."

He then added, after a pause, "But I *would* say that it *could*."

There followed a mass of dogmatically stated medical evidence in behalf of the defendant. The judge awarded damages for the injury, then called that last medical witness for the plaintiff back as he was leaving the courtroom and told him how particularly helpful his testimony had been.

In spite of keeping careful records and spending an appreciable amount of time in preparing to testify, the physician on the witness stand may encounter some unexpected difficulties. I recall a case in which the cross-examining attorney reeled off a long list of symptoms and physical signs, asked whether they would warrant a certain diagnosis, and wound up with a belligerent, "Answer yes or no." Of course, a yes or no answer is sometimes appropriate. But this particular question was like that famous old example, "Have you given up beating your wife yet?" and could not be answered well either way. The testifying physician, obviously at a loss about what to say, began arguing with the attorney. Then the judge ordered the witness to give a yes or no answer or be found in contempt of court. After hesitating for a moment the physician gambled on a "no." This was at once pounced upon by the cross-examiner. He contrived to develop it into something detrimental to the party in whose favor the witness was appearing, at the same time making it look as though the physician had contradicted himself.

It will be helpful to any physician confronted by such a situation to bear in mind that, while a judge has the power to order that a question be answered, no one has a right to tell a witness how to answer a question. The witness is under oath to "tell the truth, the whole truth, and nothing but the truth." If neither a "yes" nor a "no" answer will fulfill the obligation of that oath, a good reply would be, "I cannot truthfully answer that question either yes or no. The truth of the matter is. . . ." The physician then should continue with an explanation that will convey the true picture. It is hard to see how any judge could order a physician to answer yes or no in the face of such a statement.

It is hoped that this discussion of the problems selected may help the physician to prepare for a court appearance and to feel more at ease on the witness stand. It may also assist medical witnesses to do full justice to the causes of litigants in whose behalf they appear, to give their testimony in such manner as to establish a good relationship with judge, jury, and legal counsel, and to maintain the prestige of the medical profession.

Yukon Health Service

A full public health service for all persons in the Yukon has been announced by Mr. J. Waldo Monteith, Minister of National Health and Welfare. The new service is operated by the Indian and Northern Health Service of the Department in co-operation with the Territorial Government, the cost being shared.

The service is aimed at providing for every Yukon family a gradually increasing level of public health care, with the advice and co-operation of the family physician. It provides classes in mothercraft, the continuation of the immunization program against diphtheria, whooping cough, tetanus, smallpox, and poliomyelitis, health inspections of school children and of school premises in co-operation with school authorities, home visiting by the public health nurses, health information to the community through various channels, the inspection of premises used by the public in co-operation with the Territorial Government's sanitarian, and advice on measures designed to assist public health. (From *Canadian Weekly Bulletin*, Feb. 26, 1958.)

Radiation Research in Historic Nagasaki

Phyllis Mann Wright, M.D.

AT THE COMPLETION of my husband's and my own formal medical training, the question of whether to enter private practice of pediatrics or to remain in academic pediatrics was still unresolved. We finally decided to turn this period of indecision to our advantage by spending some time in a foreign country. We hoped in this way to broaden our horizons both medically and socially while we planned our future medical careers with the perspective afforded by "getting away from it all." Accordingly, we spent what we now agree were our two most interesting years, from 1950 to 1952, living in the city of Nagasaki, Japan, as members of the Atomic Bomb Casualty Commission, a research team of American and Japanese scientists engaged in investigating the long-range medical effects of atomic radiation.

After flying to Tokyo via Alaska and the Aleutians, we spent a week's indoctrination period at the Commission's main laboratories in Hiroshima, and then proceeded south to Nagasaki by train. Our initial enthusiasm was considerably dampened by the advent of a terrible typhoon and the depressing fact that our train was a troop train carrying American soldiers to a port of embarkation for Korea. (The Korean war had begun three months before we left the United States.) The usually punctual Japanese train arrived in Nagasaki approximately 12 hours late due to frequent delays to clear the rails of parts of houses and other debris which the typhoon had blown onto the tracks. However, despite the unfortunate first few hours, we spent the next two years enjoying almost every minute of our life in Japan.

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NAGASAKI AND THE WESTERN WORLD

Nagasaki as we knew it was a city of a little more than 200,000 inhabitants, situated at the southwestern tip of Kyushu, the southernmost of Japan's four main islands. Although the city will probably be most remembered as the site of the second atomic bomb attack, it has a long and fascinating history of contact with the western world, beginning in the sixteenth century.

In 1549 Saint Francis Xavier landed near Nagasaki and began sowing the seeds of Christianity among the Buddhist Japanese. Shortly thereafter, Spanish and Portuguese trade began and flourished along with Catholicism. However, by the middle of the seventeenth century the Japanese feudal lords began intense persecution of the Spanish and Portuguese, whom they suspected of attempting to weaken the influence of the war lords over the Japanese people. Only the Dutch (of the Dutch East India Trading Company) were allowed to continue to trade because they appeared at that time to be disinterested in converting the Japanese to their religious beliefs. In 1640 the war lords climaxed several years of persecution by massacring all the known remaining Christians and effectively closing Japan's doors to any contact with outside nations for the next 200 years. The only exception was the small colony of Dutch traders whose activities had been confined to the tiny island of Dejima in the Nagasaki harbor. Through this narrow channel knowledge of Western medicine, astronomy, botany, mathematics, and other sciences continued to flow to the Japanese people. The Dutch on Dejima remained Japan's only liaison with the outside world until 1854, when Commodore Perry reopened the door to Japan with the Treaty of Peace and Amity between Japan and the United States. In succeeding years foreigners

of many nationalities returned to Nagasaki. The Chinese took over a large section of the city and the Russian fleet spent the winters in the temperate waters of the Nagasaki harbor.

In 1887 a French author, Pierre Loti, wrote a book entitled "Madame Chrysanthemum," based on a romantic interlude that occurred when he was stationed in Nagasaki as a naval officer two years previously. This story served as the inspiration for Puccini's opera, "Madame Butterfly." On our first sight-seeing tour of Nagasaki we climbed the hill to a lovely old rambling home with spacious gardens and a breathtaking view of the harbor, the tile-roofed city, and the green-terraced mountains, and were assured that "this was Madame Butterfly's house." Later we were offered this house as our residence during our stay in Nagasaki, but practicality triumphed over sentiment when we discovered that the roof leaked badly and that the house actually belonged to an Englishman named Thomas Glover.

From the terrace of "Madame Butterfly's house" we looked across the harbor to the huge Mitsubishi shipyards where Japan's two largest battleships were built during World War II, and where now under British and American supervision the Japanese shipbuilders are producing large ocean-going tankers. Other industries for which the city has become known include fine lacquer ware and articles of tortoise shell, as well as a distinctive type of blue and white china reminiscent of the old Dutch designs.

AFTER THE ATOMIC BOMB

There is little evidence today of the massive destruction caused by the atomic explosion, as almost the entire area has been rebuilt except for the Nagasaki University Medical School and the Urakami Catholic Cathedral, which are in the process of being restored. There is a little park, a museum, and a monument at the hypocenter to remind the world that at 11:02 a.m. on Aug. 9, 1945 the second atomic bomb was detonated over the city. The military targets were a torpedo plant and a small arms factory located approximately two miles from each other in the Urakami Valley. The explosion effectively destroyed both targets and brought death to over 33,000 of the city's 250,000 population, and injury to an equal number, while bringing about the end of World War II.

Remains of the Nagasaki University Medical School.

Sign at the hypocenter.

The U. S. government soon realized that the survivors of the Hiroshima and Nagasaki blasts might provide important information regarding the long-term effects of atomic radiation on the human race, and since 1948 the Atomic Bomb Casualty Commission has been engaged in a number of research projects in this field.

Among the programs in which we participated was a study of the outcome of pregnancy in women who were pregnant during exposure to the Nagasaki atomic bomb.[1] Of 30 mothers who had major signs of radiation sickness, that is, epilation, oropharyngeal lesions, purpura, or petechiae, there were 7 fetal deaths, 6 neonatal and infant deaths, and 4 instances of mental retardation among the 16 surviving children, an over-all morbidity and mortality of 60 per cent as compared to 6 per cent in a control group. The evidence suggested that radiation, either directly to the fetus or indirectly as a result of its effect on

the maternal tissues, was of considerable importance in determining the outcome of these pregnancies.

Another study linked atomic radiation with leukemia,[2] since it was discovered that the incidence of both myelogenous, lymphatic, and stem cell leukemia was many times higher among heavily irradiated survivors than in the Japanese population as a whole. This relationship, of course, was already suspected because of the higher death rate due to leukemia among radiologists as compared to physicians in other specialties.

Our group also studied the survivors for evidence of radiation cataracts, which had previously been observed both in laboratory animals and in several scientists working with cyclotrons in America. Among the survivors who were within 1,500 meters from the hypocenter, 47 per cent had detectable lenticular opacities but their vision was not seriously impaired.[3]

One of the most comprehensive studies, which recently has been terminated, was the Genetics Program in which all babies born in Hiroshima and Nagasaki from 1945 to 1953 were studied for developmental anomalies.[4] Reassuringly, there appeared to be no statistically significant differences between babies born of nonirradiated parents and those whose fathers or mothers had been heavily irradiated. However, sufficient time has not yet elapsed to detect genetic mutations that may occur in future generations of the Japanese people as a result of irradiation.

A growth and development program designed to compare the stature and general health of 300 heavily irradiated Nagasaki school children with 300 paired controls

The Urakami Valley after the atomic bomb.

Members of the Atomic Bomb Casualty Commission research team check the baby of a woman who survived the atomic explosion in Nagasaki.

showed that, at the time of the study six years after the bombing, the exposed group of children were very slightly shorter and lighter in weight than the nonexposed control group. However, this difference could not be definitely attributed to radiation since the effects of malnutrition, dysentery, and other diseases that followed in the wake of the bombing, as well as the psychological trauma to the children (many of whom were orphaned), had to be considered.

The experience of carrying on medical research with scientists of a foreign country, and of having the opportunity to enjoy the beauty and culture of one of the world's most historic cities, proved most rewarding. Anyone with a similar taste for travel might well spend a year or two in this type of endeavor before becoming tied down by the demands of the private practice of medicine or entering the field of teaching and research in this country as we finally elected to do.

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A Citizens' Basic Health Training Program

Ruth J. Temple, M.D., M.P.H.

AUTHENTIC REPORTS show that well-organized community health programs have high human values. Dr. Ralph Sachs and associates reported that their integrated community program in Richland had helped reduce mortality rates to half those of the nation and had resulted in estimated savings of nearly 750 thousand dollars annually.[1]

This present article deals with the Citizens' Basic Health Training Program, which we are working to develop in Los Angeles County and which it is hoped will be of value to people in other areas of our country and the world.

A little more than 13 years ago a few of us, who later formed the Community Health Association, expressed the following basic concepts:

1. Health is wholeness of the total personality, bound up inseparably with human development, happiness, and service, and with the abundant life that is from God, the Creator.

2. All human beings everywhere suffer from costly, deadly, preventable physical diseases, mental or emotional disorders, and human tragedies that medical science, psychology, and sociology, with spiritual resources, can cure or prevent.

3. Each individual and family has a health responsibility. Incapacitated by ignorance, indolence, and irresponsibility, human beings are almost totally unprepared to use available resources and to do their part in preventing disease and tragedy and in promoting positive health.

4. All citizens need basic health training to help them become health-prepared citizens who know, practice, and communicate to others basic health principles, processes, and procedures.

With firm belief in the foregoing concepts, the Community Health Association members looked at health needs of low-income families in Southeast Los Angeles. Called to this area early one morning, I found a baby ill with pneumonia. A hospital bed was available, but this was refused. The mother said, "I love my baby. When he is sick, I cannot let him go among strangers." Hydrotherapy and other available remedies offered were refused also. Because of the mother's ignorance, superstition, and deep fear, I was forced to stand by and see this baby die without benefit of available hospital care or remedial measures that were at hand. This case was a determining factor. It helped Community Health Association members to see wonderful possibilities in health education and to dedicate themselves in faith to development of a Citizens' Basic Health Training Program.

Dr. Temple is Director, Special Health Services of the Los Angeles City Health Department; Founder of the Community Health Association; and General Chairman of Health Week and Health Study Club Programs.

HEALTH TRAINING PROCESSES EMPLOYED

Annual Community Health Week – the County-Wide Operation Citizens-Alert. This wakes up the community, informs citizens of their health needs and valuable health resources, and helps them begin participation in the Citizens' Basic Health Training Program of continuing health learning, health practices, and communications.

Health Study Clubs–Operation Citizens-Preparedness. Leadership Health Study Clubs for teachers and other leaders follow Community Health Week, and Neighborhood Health Study Clubs for individuals, families, and community groups follow Leadership Health Study Clubs.

Private physicians, clergymen, educators, public health department and voluntary agency workers, and other prepared leaders are Health Study Club faculty members or instructors. The aim of the Health Study Clubs is to work in co-operation with Community Health Week and community agencies and to help all citizens of all ages to take 3 A B C health steps:

Step III	(C)OMMUNICATING TO CONTACTS that which is being learned and lived day by day.
Step II	(B)RINGING INTO PRACTICE WHAT IS LEARNED regarding early health examinations and preventive and curative treatment; nutrition and other phases of healthful living; and daily practice of moral and spiritual principles of abundant living.
Step I	(A)CQUIRING BASIC HEALTH KNOWLEDGE offered by medical science, psychology, and sociology, with spiritual resources.

Health Information Centers–Operation Citizens-Recruitment. These, set up in strategic sites, attract casual passers-by, supply pertinent information, and encourage Health Study Club participation.

Block-to-Block Plans – Operation Family-Participation. These are carried out in a small nine block area and help Health Study Club and family members to plan "See Your Doctor Days" and to follow through with their private physician, if possible, or with available health department services, if necessary, for needed examinations and protective and curative treatments, and with daily principles and processes of health and abundant living in the home, church, school, and community.

OPERATIONS CARRIED OUT IN LOS ANGELES

Annual Community Health Week and follow-up Health Study Clubs, health information centers, and block-to-block plans of work are carried out as a continuing integrated Citizens' Basic Health Training Program. Under sponsorship of the Community Health Association and with the united efforts of the Los Angeles County Medical Association, the Los Angeles city and county health departments, city and county schools, and other responsible voluntary and official agencies, this work was launched in 1945. During the past 13 years programs conducted have included the following operations:

Thirteen Annual County-Wide Community Health Weeks. The vice-president, secretary-treasurer, past-president, and some Trustee Board members of the Los Angeles County Medical Association; other private physicians; public health department and voluntary health agency workers; educators; chamber of commerce, labor, business, and civic leaders; and religious leaders of the Protestant, Catholic, and Jewish faiths are all active members of Health Week Planning Committee. As many as 97 cities, districts, or neighborhoods in Los Angeles County have participated. Approximately 1 million city, county, and religious school-sponsored students and teachers have helped in programs. Approximately 1 million members of local P.T.A.'s, of organized labor, and of religious and business groups are active annual participants. The highlight of the "Week" is an all-day Health Week Conference, Leadership Luncheon, and Health Show in the Biltmore Bowl and Theatre.[2] Each year there are overflow crowds, and large numbers are turned away.

Twelve Annual Leadership Health Study Club Courses. These training courses for schoolteachers and other community leaders have followed Health Weeks.

Demonstration Neighborhood Health Study Clubs. These have been set up in city and county schools, theaters and night clubs, colleges, churches, P.T.A.'s, housing projects, and beauty schools.

A Demonstration Health Training Center. This was established and operated for five years and featured health exhibits, "Community Health Days," nutrition demonstrations, and other phases of the Citizens' Basic Health Training Program.

ALL COUNTIES CAN BECOME DEMONSTRATION CENTERS

Citizens of all counties in our country can develop a Citizens' Basic Health Training Program. These programs can prove increasingly effective to each county and be valuable as demonstration areas for other counties.

The Community Health Association, just

emerging from its demonstration stage, and working for a larger, more effective program, is glad to share its experiences and to give interested groups any information or assistance possible.

SUMMARY AND CONCLUSIONS

It is believed that: 1. A Citizens' Basic Health Training Program promotes self-help and brings health resources of science and spirituality within reach of all people. 2. In any community where residents exercise faith in God, assume personal responsibility, and enter earnestly into developing an integrated, continuing Citizens' Basic Health Training Program, citizens will be prepared and motivated to help: wipe out preventable, physical, and mental diseases; eliminate preventable human tragedies; and promote positive health or wholeness for the individual, the family, and the total society.

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Valuable Leaflet in Management of Rehabilitated and Ambulatory Cardiac Patients

A new leaflet titled "What We Know About Diet and Heart Disease," summarizing what is known to medical science by way of answers to these questions, has been issued by the American Heart Association and its affiliates. The leaflet was prepared in response to hundreds of inquires from the public.

Copies of "What We Know About Diet and Heart Disease" are available from the American Heart Association, 44 E. 23rd Street, New York City 10, or from local Heart Associations.

Accident Facts

The Statistics Department of the National Safety Council has released the accident figures for 1957: killed, 95,000 (all accidents); injured, 9.5 million; and the cost, 11.8 billion dollars.

The death toll compares with a total of 94,780 in 1956; but, despite the lack of change, the population death rate went down 2 per cent (from 56.7 to 55.8) because of increased population.

Motor vehicle accidents remained the number one killer, even though there was a 3 per cent decrease in traffic deaths in 1957. Home accidents claimed the second largest number of lives, although the 1957 total dropped by 500 to 27,500. Falls, always a heavy killer, brought death to 20,700 persons in 1957— 2 per cent more than in 1956. Deaths from burns numbered 6,700—up 5 per cent from 1956. Drownings totaled 6,700—up 7 per cent from 1957. Firearms deaths numbered 2,250, or 2 per cent more than in 1956.

The 1957 all-accident death rate of 55.8 per 100,000 population was only the fourth time in the history of accident records that the rate has fallen below 60. The 1957 rate was 23 per cent under the rate for 1941. Nevertheless, 1 out of every 18 persons in the United States suffered a disabling injury in 1957. The estimated economic loss of 11.8 billion dollars from accidents in 1957 covers both fatal and nonfatal accidents and includes wage losses, medical expense, and overhead costs of insurance for all accidents, production delays, damage to equipment in work accidents, and property damage from traffic accidents and fires.

General Practice: Advantages and Disadvantages

Juyne M. Tayson, M.D.

ADVANTAGES

THE GREATEST ADVANTAGE in general practice is the feeling of personal satisfaction, for the general practitioner is always nearest the basic family group. At the end of almost every week, the general practitioner can look back to having helped more individuals and family groups through minor as well as major medical and surgical problems than can any other branch of medicine. Why is this? Because a good general practitioner will almost always double or even triple the number of patients seen in a week in comparison to the specialist.

This busyness in itself is an advantage. Most physicians after finishing a busy internship or residency are primed to a very active life. To then find oneself in a specialty seeing only 4 to 10 patients a day for a year or so can prove to be deadly and uninteresting.

General practice keeps you on your toes, for there is almost never a monotonous day. The large variety of patients seen in general practice provides a challenge and lively interest. A good general practitioner must be well versed in all branches of medicine and surgery and at the same time realize her limitations.

DISADVANTAGES

The disadvantages are present to a greater or lesser degree in almost all branches of medicine. The greatest disadvantage is the 24 hour call schedule, making it difficult to plan a week end or even a definite night off. The obvious answer to this problem is partnership or group practice.

The large number of house calls also presents a disadvantage. The younger physician tolerates house calls well, but, with every year of added practice, the number of house calls and hospital calls multiplies. However, the physician's judgment also sharpens in deciding what house calls are really necessary.

Another disadvantage is the irregular hours. Many specialties such as dermatology, radiology, physical medicine, pathology, or ophthalmology offer comparatively regular hours. Not so, general practice. Here the hours are not only irregular, but the total number of hours spent is greater than in the specialties.

Dr. Tayson has been engaged in general practice in Los Angeles for eight years and is a Staff Member of Memorial Hospital, Glendale, and of French Hospital, Los Angeles. She is also President of Branch Twenty-Three, AMWA.

QUALIFICATIONS

I have often been asked by medical students, "What type of person makes a good general practitioner?" I think the prospective general practitioner should have an extroverted personality. There is no place in general practice for the shy, introverted physician who is afraid of people or of meeting emergencies. Approximately one fifth of my practice is emergency treatment: all the way from burns, fractures, and lacerations to major medical emergencies such as cardiac infarctions and diabetic comas.

The general practitioner should have a warm personality. To be successful she should show a warm interest in all members of her medical family from grandmother to grandchild. Oftentimes the general practitioner will work hand in hand with other groups such as the clergy and school personnel in solving the emotional as well as the physical needs of a patient.

The physician who is clumsy and inadept with her hands should stay away from general practice. Almost all general practitioners that I know do a large amount of surgery. Tonsillectomies, dilatation and curettage, and hemorrhoidectomies are everyday occurrences, and major surgery also poses no problems for a general practitioner who is well associated with a good general surgeon.

The prospective general practitioner should have a strong affinity for obstetrics. She

should learn well the technique of spinal anesthesia and acquaint herself with the numerous spinal medicating agents. She should be well skilled in the use of outlet forceps, breech extractions, and the mechanisms of delivery in abnormal presentations. Early in my career I acquainted myself with several competent obstetrics-gynecology specialists, and I do not hesitate to have a consultation whenever I have a difficult or an operative delivery.

General practice gets the lion's share of geriatric patients. There is no single group of patients who demands so much time and understanding as does the oldster. It is true that at times they tax the physician to the limit of her patience, for they have a continual parade of multiple problems. One thing is certain though; on the whole, these patients are the most loyal and faithful of all and literally remember their physician in their prayers. I do not think that any physician should go into general practice unless she has a feeling of compassion for the oldster, for mere toleration on the physician's part is not enough.

The Illness with Many Names

In Central Africa they call it "kwashiorkor," in South Africa "infantile pellagra," and in Jamaica "fatty liver disease" or "sugar baby." In the Belgian Congo it is sometimes called "M'Buaki," in India, "nutrition dystrophy" or "nutritional oedema syndrome," and in Latin America "distrophia pluricarencial infantil." These names, and dozens of others in different languages, all mean the same kind of sickness in young children: protein malnutrition.

It is only in the past few years that the world's nutrition experts have become aware of the extent and seriousness of this form of malnutrition. In some parts of Africa every child suffers from it at some time of his life. Its signs and symptoms are always the same, and usually take the form of serious digestive upsets. Many mothers react to these upsets by putting their children on a near-starvation diet, but this only makes them worse. In the majority of cases, the most effective treatment is simply to put the child on a diet of protein-rich skim milk. Often, this restores even gravely ill children to health in a matter of weeks.

In some countries there is no milk for children other than their mother's and, when they are weaned, they pass directly to the ordinary diet of the family, which is usually poor in protein. Moreover, when foods rich in protein, such as meat, fish, or eggs, do appear on the family table, they are generally reserved for the adults. This leads to protein malnutrition, the effects of which may range from a mere slackening in the growth rate to serious disease and death.

The United Nations Food and Agriculture Organization has stepped in to tackle this tragic problem. Together with the World Health Organization, it has organized surveys and arranged regional conferences that have brought protein malnutrition into the scientific limelight.

FAO is working to promote increased milk production in many countries and, simultaneously, to raise milk consumption. The U.N. Children's Fund (UNICEF) has distributed nearly 600 million pounds of dried skim milk, and has also helped to establish milk processing plants in several underdeveloped lands. In many regions, however, it is not possible to produce enough milk for child feeding. Other palatable and easily digestible protein-rich foods must be substituted.

One of these is an emulsion of soybean, often called soybean milk. It has been known and used by the the Chinese for centuries. In other parts of Asia, particularly in Indonesia, Thailand, and India, and in the Philippines, experiments with soy and peanut preparations are being carried on. Several soybean preparations sold on American and European markets for children allergic to milk have been used successfully, but are too expensive for use among poorer populations.

FAO is also encouraging experiments in the use of press cake, the material left after the oil has been crushed from various oil seeds or nuts, such as peanuts. And peanut flour, like soy flour, has been found a very satisfactory supplement to the proteins of maize and other cereals.

Of the various animal products rich in proteins, fish is a food that often can be obtained in large quantities at reasonably low prices. FAO has played an important part in advising on methods of increasing world fish yields from both fresh and salt water. It has also recommended the inclusion of fish in the school feeding programs of South and East Asia. This is now being done extensively in the Philippines, Japan, and Indonesia.

People must be taught how to make better use of locally available proteins, and mothers must be made to understand the nutritional needs of their children. Thus, the problem of raising the protein content of the diets is not just a technical problem of greater production. It is a sociological and educational problem as well. (*UNESCO*)

Around the World in Forty-Two Days

Elizabeth Mason-Hohl, M.D.

IN THE 1920's MY GOOD FRIEND, the late Dr. Olga Stastny of Omaha, was making headlines for her work with the American Women's Hospitals on Macronissi Island.

In September, 1957, I stood on the hills of Sounian in Southern Greece and looked long and thoughtfully at that island. In the twenties the Turks had driven the Armenians—those they had not killed—out of their homeland. Greece gave them refuge.

Dr. Stastny was selected to go with these thousands of homeless, hungry, diseased, vermin-ridden men, women, and children to the barren, waterless island of Macronissi off the Greek shore. The saga of her heroic work there with a handful of soldiers as helpers came back to me, and I wished she could know that now the island is a peaceful penal colony where Greece keeps its political enemies and its youths who do not know right from wrong. As they prove their patriotism and worth, they are graduated from one colony to another until their rehabilitation is finally complete and they are welcome in Greece.

The World Medical Association was meeting in Istanbul in late September, 1957. Dr. Alethea Dollinger and I left Los Angeles by Scandinavian Airways System to go over the great polar icecap to Copenhagen, with a refueling stop at Winnipeg. The story of the trip, our visits to Copenhagen, Vienna, Rome, and Greece, are probably the same as any tourist can tell. We were due to leave Athens for the Holy Land at the time of year that the religious pilgrims had priority, so, as guests of Trans-World Airways, we prolonged our stay in Greece and missed the Holy Land. The sentimental thrill of seeing Macronissi and going over in my mind the Stastny expedition was well worth the disappointment.

We finally got out of Greece by B.O.A.C. plane to land in Istanbul and the Istanbul Hilton Hotel as the convention got under way. The seriousness with which the delegates and observers considered the health problems of the world's humanity, the special problems of the physicians in Cuba, and the policies of the medical writers and editors of the world were most impressive.

The physicians of Turkey were cordiality-personified—the banquets, the trips on the Bosporus Golden Horn and Marmara, the day-long trip to Bursa, the mosques, the covered bazaars, the palace parties, the two boat rides to Princes Islands, and the sincere friendship of everyone we met made us grateful indeed that we had traveled so far.

In Istanbul we joined the World Medical Association's "Round the World Tour with Tailored Travel of New York and Paris." There were 38 of us in the party, including five women physicians: Drs. Sarah Rosekrans, Alethea Dollinger, Elizabeth Cannon, Annis Thomson, and myself. We flew to Bombay by way of Cairo to get our first view of the land of Gandhi and Nehru. We visited hospitals and research projects; saw sacred cows by the hundreds, great poverty and great wealth, and the Sikh and Temples of Silence; and, as in every city we visited, were entertained royally by the physicians and their wives at theatrical performances, dinners, and receptions. Their devotion and ambitions for the health of their people, the crowded hospitals, and the diseases we know only by name gave us a concept of what is being done and what should be done to promote health and prolong productive life in Asia.

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From Bombay we went to New Delhi, where we visited hospitals and met the Indian physicians and their lovely wives at receptions; then, we went on to Agra for a visit to the Taj Mahal, and a personal experience with a Colles fracture sustained in the Red Fort. From Agra we went to Jaipur, the Pink City, visited its government hospital, and took an elephant ride to the Amber Palace; then, in Benares we took a trip on the Ganges at 6 a.m. and viewed life on the river bank and the burning of the dead on the Ghats. This sacred river is said to be free of disease-producing germs. Not one of us would take a chance of bathing in it and drinking the water as these people do everyday as a religious rite. The floating dead babies, the priests and beggars, the lepers who bathe in the water and who later go to sit or lie and beg on the steps, the cows, the unburned remains of the dead—all these would stop us. It is all there to see, and also the holy temples where one is required to go barefoot. There, too, are the brocade factories where the most beautiful materials in the world are woven by little children—such a mixture of the beautiful and, to us, the revolting.

By automobile we drove many miles through very poor villages with common open wells, sacred cows, and innumerable human beings, monkeys, parrots, elephants, and camels. Over dry, dusty roads we drove back to New Delhi, the model city, with its beauty and comforts, its splendid government buildings, its great shopping circles, and the revered tomb where rest Gandhi's ashes.

On then by plane to Calcutta, again to be greeted by our local travel agency with *leis* and by the members of our profession. We were entertained at luncheon and dinner and shown their hospitals where we again were impressed by the great numbers of sick people and the varieties of diseases—impressed, too, by the sincerity of the physicians. There are holy cows here too, and beggars and covered bazaars; in fact, everything that any huge city in India has, Calcutta seems to have more of.

From Calcutta we went to Bangkok and experienced a complete change of climate. In contrast to the aridity, scant vegetation, heat and dust of India, Bangkok had pouring rains, dense vegetation, and insects that seemed hungry for our skin and blood. Also, the feeling we received was that there was no deep poverty and surely no hunger. We visited the government hospital, with its wards of victims of cancer, and the obstetric department, where prenatal care is practically unknown. The women came in hemorrhaging, uremic, and with all manner of other complications. Again, in spite of poor facilities, the men and women physicians and the very trim nurses are true zealots of medicine. The Adventist Hospital and Sanitarium is a model of architecture and medical and nursing care. The Director, Dr. Robert Waddell, formerly of Los Angeles, has the personality and professional attributes that give great character to the institution. Our early morning tour of the *klongs* (canals) was an amazing experience. Here scores of miles of narrow waterways teem with life. Hundreds of little boats are the tailor shops, grocery stores, the 5, 10, and 25 cent stores, and the wholesale produce mart; in fact, there is not anything that can not be bought on the *klongs*. The homes of the people stand on stilts in the water. Everybody seems happy, and we were greeted with pleasant smiles and hands waving. All of this is in contrast to the marvelous temples and royal residences of the king, all indescribably beautiful. We, walking barefooted, saw the reception rooms, the great urns where the dead king is kept 100 days before public cremation, the emerald Buddha, and the typical Siamese (now they are Thai, meaning true) roofs.

A reception given at the medical association building gave us the great pleasure of again meeting with our Thai confreres. Two of the women were especially interesting: The younger was an obstetrician; the other was a woman who, appalled by the number of deserted children, has adopted 61 of them—the oldest of whom is now in medical school in Paris. Hers, a real home for children, has at last received national recognition, and she receives funds from the general public to assist with the maintenance of the home and the education of the children. Dr. Pierra Vejjabul is a woman of stature in Thailand, in spite of her less than 5 feet in height.

A plane took us to Hong Kong, with its great scenic location, and Kowloon, easily reached across the bay. The Gloucester Hotel, where we stayed, is in the very center of the shopping district so we had suits made, bought beautiful satins, Kodaks, and embroideries, and wished that U.S. customs would allow us at least twice our 500-dollar import. As guests of the physicians of Hong Kong we visited one hospital in Happy Valley which was so new and so modern that we could not help

but compare it to some in our homeland that are not so new and modern. The staff and patients have a wonderful advantage—the balconies of the hospital overlook the racetrack! Our Hong Kong confreres and our travel agency had a reception and dinner for us at Cafe de Chene and a special luncheon on the Floating Restaurant at Aberdeen.

A sight-seeing tour included Repulse Bay, Kowloon, and Victoria Peak; in fact, I am sure we saw everything, and we will long love Hong Kong, from its fabulous fabric shops, to its slim, lovely sheath-clothed young women, its climate, and best of all, for Dr. Rosekrans, Dr. Dollinger, and myself, tea at Government House with Lady Grantham, wife of the governor general. This was planned by our friend, Marie Leigh of Kowloon. Lady Grantham, a Nebraska-born, California-raised lady, is greatly interested in Hong Kong's cancer problem. The gardens of "Tiger Balm" fame and the deceased owner's home with its collection of paintings, statuary, and jades were a special treat for us. The little granddaughter was a delightful hostess.

Our Japanese Airlines plane carried us from Hong Kong to Japan by way of a refueling stop at Okinawa, with its quonset huts, and over Formosa. We could not buy anything in Okinawa because the only money used at this U.S. base is military script. It was interesting to see this island, so fought over during our war with Japan, become now a U.S. military base.

Tokyo came at dusk. The Japanese Medical Association, with its president and other officers, met us at the airport with a huge welcoming banner and speeches. (As we left Tokyo we saw similar banners welcoming an agrarian group from Russia.) We stayed at the Imperial Hotel in Tokyo, near the Imperial Palace moats and Ginza Street. Frank Lloyd Wright was the architect of the hotel, which gives every evidence of being a wonder of the world. It was a long walk from the front door to our room in the long new wing. The hotel is the crossroads meeting place for world travelers and almost every day one will meet friends there.

In no place in the world probably are there as many or as fantastic neon signs as in Tokyo. We saw no sacred cows. The people are about evenly divided as to wearing apparel (about half wear Japanese costumes). Everywhere there are huge, substantial buildings being erected. There is always a sight-seeing crowd trying to view the Imperial Palace. No one gets close to it. General of the Army, Douglas MacArthur, helped to get rid of feudalism and all royalty, excepting the one royal family. The red torii gates seen all over Japan indicate a temple (Shinto) where ancestors are worshipped.

Education is compulsory in Japan. Tokyo University has 10,000 men, 400 selected women students, and a library of 21,000 books and scrolls. No matter where we went there were dozens of busloads of uniformed school children from all over Japan with chaperones and guides visiting the shrines, temples, and public institutions. Beautifully respectful and certainly well-behaved, they concentrated on the business at hand. Great classes of children of all ages spend days sketching landscapes, trees, and people.

Government-regulated prostitution is an age-old institution but will be outlawed within the year, we hear. Driving in a locked taxicab one evening in the first, second, and third-class districts of Tokyo, we saw the "girls" in the doorways bidding for business. Most of them in the first-class district were pretty and dainty in their geisha costumes; they all have to be over 22 years of age. In the second-class districts the women were older, less beautifully gowned, and more eager. In the third-class districts the poorer class of women entertain the poorer class of men "American style" (the call house system). The entire picture nauseates one.

Our guide told us that twelfth century history records Japan as part of China though it had its own arts, crafts, and medicines. Each new emperor abandoned the city of his predecessor to found his own city, so that, in turn, Nara, Osaka, Kyoto, and Tokyo have been among the capitols. The clan system was outlawed in the seventh century, but the people were not much better off during the feudal system. Since the last war there are no feudalists or war lords; in fact, there is now ownership of property by the people, and there seems to be prosperity.

The government-owned Communications Hospital, which we visited, is a mammoth building, with the very latest equipment and many very worth-while features not used in the United States. Our shoes were left at the maternity and surgical department doors just as they were at shrines, temples, and monuments. Cancer is said to be common in men—cancer of the stomach predominates. Very lit-

tle anesthesia is used during deliveries, although many of the physicians who entertained us had courses in anesthesia in the States.

We visited Nara and the Diabutsu-den, Kyoto, Yokohama, The Great Buddha, Osaka, Necchi, and the Fujuja Hotel in Fuji Hatun National Park. Each was different and interesting. Kyoto, because it is still truly old Japan, with lacquer, cloisonné, damascene, and silk factories, was most educational. We visited tea-packing plants, eel beds, and a geisha party, which was considered typical Japanese entertainment. We were guests of our Tokyo confreres at a Genghis Khan dinner in a 1,200 year old pagoda garden. We learned about Mikimoto pearls. In fact, all of Japan intrigued us; even though we had to see the top of Fujiyama first and then the lower slopes (because of clouds), even though we were often baffled by their toilet facilities, and even though to us their respectful bowing seemed overdone, yet we left Tokyo by Japan Air Lines much impressed by our visit.

In our Happi coats on our special plane for Hawaii we were taken by bus to a restaurant in Wake Island for breakfast, having crossed the international date line. Wake is a placid and beautiful island from the air, but it was hot and wet when we were on it. Hawaii was eight and a half hours away—surely the world's present Garden of Eden. We relaxed on Waikiki Beach, taking time to review our 42 days of travel. The world is a wonderful place. Not all of its countries are favorably placed and the great majority of its inhabitants are underprivileged, undernourished, and surely lacking medical and hygienic care. But, the physicians of the world whom we met were one family with us, sharing our common objective—good health, long life, and happiness for everyone.

Juvenile Delinquency

"Confronted with the worrisome problem of juvenile delinquency one lone writer summed up the situation in his vicinity in these blunt words: 'Our youth now love luxury. They have bad manners, contempt for authority, disrespect for older people. Children nowadays are tyrants. They no longer rise when their elders enter the room. They contradict their parents, chatter before company, gobble their food, and tyrannize their teachers.' Of interest is the fact that this is not a quotation from a recent writer, but these are the words of Socrates, written in the fifth century before Christ." (Fisher, C. C.: *J. Pediat. 51*:602, Nov., 1957.)

Research on Aging

The relationship between cardiovascular disease and the problems of aging is being studied by Dr. F. Marott Sinex of the Boston University School of Medicine. A two year grant of $43,000 from the U.S. Public Health Service will enable Dr. Sinex to study the molecular changes in collagen associated with aging.

Dr. Sinex is a biochemist interested in the reasons for aging from a biochemical standpoint. The research deals with the two principal proteins found in connecting tissues, in the blood vessels, and in the skin and bones of the body. Dr. Sinex, by focusing his study on the changes that occur in the protein molecules of blood vessels, is determining the effects that molecular aging has on the chemical properties of vessel tissue in the human body.

Hospital Beds

Although hospitals belonging to nonprofit organizations have only one fourth of the nation's hospital beds, they own almost half the total hospital assets in this country, according to Health Information Foundation. Such hospitals rank high in provision of special facilities and services.

Medical Briefs

SYPHILIS

The total number of reported cases of syphilis in all stages has risen in the United States for the second consecutive year. During 1957, 135,542 cases of syphilis were reported as compared with 126,219 in 1956 and 122,075 in 1955.

This fact was revealed in the fifth Annual Joint Statement, "Today's VD Control Problem," based on a nationwide survey conducted jointly by the American Social Hygiene Association, the Association of State and Territorial Health Officers, and the American Venereal Disease Association.

Commenting on the Joint Statement, Conrad Van Hyning, ASHA's Executive Director, said: "The facts at hand are significant. They show that the false sense of security that virtually eliminated Federal support in 1953-1954 has now been replaced by increasing attention to the VD problem, with satisfactory results. A partial restoration of Federal funds has permitted states and communities to intensify their control efforts. We have all learned the expensive lesson that drugs do not stop VD unless they are deposited in human tissue."

The information in the Joint Statement was compiled from individual reports of health departments of all 48 states, 3 U. S. territories, 95 out of the 107 cities in the U. S. with populations of 100,000 or more, and the District of Columbia. The survey therefore represents a thorough and authoritative canvassing of the country's VD problems and program needs.

The 1957 increase in the total number of reported cases of syphilis results primarily from an increase in late and late latent syphilis, of which 100,514 cases were reported—the highest number since 1952.

Cases of primary and secondary syphilis reported show a slight decline, and early latent syphilis shows a slight rise. In neither case, however, is the fluctuation sufficient to change the rate per 100,000 population to any great extent.

RADIATION HAZARDS

A program at New York University-Bellevue Medical Center concerned with hazards of radiation as they are found in the environment has been made possible through a $500,000 grant from the Rockefeller Foundation.

Dr. Norton Nelson, Director of the Center's Institute of Industrial Medicine and Professor and Chairman of the Department of Industrial Medicine in NYU Post-Graduate Medical School, will direct the activities of the new program. Dr. Nelson stated, "Attention will be directed both to radiation hazards for the general population and to the special risks arising in industrial applications. The guiding objective will be evaluation aimed at prevention or control of the hazard. It may be necessary to call on a diversity of sources for the necessary data: the ecologic movement of radioactive materials through intermediate hosts to man, human genetics, the epidemiology of radiation effects, and the physical and biological factors that determine radiation dosage and tissue response."

An important contribution to the effectiveness of this program will come from the recently established arrangement between the Institute of Industrial Medicine and the United States Atomic Energy Commission's Health and Safety Laboratory, which provides a basis for co-operative research and teaching between the two units. The Health and Safety Laboratory is under the direction of Dr. S. Allen Lough.

The Institute of Industrial Medicine will continue its research and teaching in the field of occupational and environmental health, and additional investigators will be added to carry out the objectives of the new radiation program.

Retiring President's Message

As I look back upon the past year, I feel that the honor of being president of the American Medical Women's Association has been a privilege for me in many more ways than I anticipated when I first consented to serve, if elected.

Unexpected and valuable experiences have come from outside the Association by virtue of the office. These have included, among many, such events as the White House invitation to the President's Conference on National Security and the invitation to lead the party of American women physicians on the exchange visit to the Soviet Union, which was exciting to contemplate up to the time when I found that I should be obliged to decline.

The most significant joy has been the gracious and ardent co-operation that I have received from both the officers and members, the loyalty of my own branch members, the sacrificial devotion of the Chairman and members of the Constitution Committee, and the tireless work of Mrs. Majally and the office staff. Many of the committees and their chairmen deserve special mention for their dedicated service to the welfare and progress of the Association in the past year.

Although I did not accomplish everything that I had hoped for, yet I feel confident that, with the able leadership of Dr. Wright and the devotion and ability of the members, the Association can anticipate steady growth and increased recognition.

May God bless all of you and all the worthy endeavors of the Association.

Elizabeth S. Kahler

President's Message

My sincere greetings to all members of the American Medical Women's Association, those whom I have met and those whom I hope to meet in person, as well as those with whom I may become acquainted only through the printed word. In greeting you this way, old and new friends, I am reminded of a few words from a Girl Scout song:

"Make new friends,
But keep the old.
One is silver,
The other is gold."

These simple words are less difficult to say than to act upon in these busy, strenuous times. However, in keeping with the import of my inaugural address, entitled "Group Participation—Keynote of the Future," I invite each of you to become active in the organization and to find some spot in which you feel you can participate. If anyone has an idea—large or small—do not hesitate to present it to somebody in the organization. It probably will be useful; however, do not despair if immediate action is not taken. Timing is vial in relation to organization functioning, but the individual's time of suggestion may not coincide with the organization's need. Do feel assured, though, that your offering of the idea to the organization makes you, at that moment, a participating member.

Katharine W. Wright

SPECIAL ARTICLE

Facts and Figures About Dutch Women in Medicine

WOMEN PHYSICIANS

IN THE NETHERLANDS, according to The Royal Netherlands Society for Medicine, there are 1,946 women physicians, or approximately 20 per cent of the total of 11,164 physicians in the country. (There is an average of one physician for every 1,000 persons in The Netherlands.)

The vast majority of the present generation are married in contrast with many women physicians of the older generation who have stayed single. The fairly large group of unmarried women physicians shown in table I is made up of the oldest and the very youngest who have just graduated. The comparatively large number of unmarried women physicians on the staffs of hospitals and other institutions are younger women who accept these positions to gain experience.

In table I the women who are listed as not working include those who have been pensioned, those who have retired from their own practice, and those who have not yet set up a practice of their own or secured a post in a hospital, clinic, or scientific institution. Many of the younger physicians do not report their first job to the Record Secretariat. The actual number of those not working is considerably smaller than the figures in table I suggest.

TABLE I

Medical Faculty—Women (1898-1956)

Type of Practice	Married	Single	Total
General practice	334	140	474
Specialty	115	79	194
Hospitals, sanatoriums, psychiatric institutes, and maternity clinics	69	230	299
Schools and other government services	57	52	109
Science institutes and teaching	27	20	47
Health centers	54	20	74
Miscellaneous, including industry, insurance companies, and locum tenens posts	20	15	35
Not working	373	341	714
Total	1,049	897	1,946

There are at present 348 women enrolled in medicine at the Amsterdam Municipal University. Among the women teaching medicine at university level, two, both married, are university professors; the others are lecturers, private lecturers, or scientific assistants.

MIDWIVES IN THE NETHERLANDS

The midwife in The Netherlands is a highly trained obstetric specialist and holder of a certificate obtained after a difficult examination at the end of three years of training.

There are three colleges for midwives, one in Amsterdam, one in Rotterdam, and one in the south at Heerleen. The total enrollment for the three colleges is between 100 and 150 students. If a student holds a hospital nurse's certificate she can complete the course in two years. Students must be between 19 and 34 years of age and pass an entrance and physical examination. At the end of the second year the students must pass an examination on their theoretical knowledge. The third year is spent working in a maternity hospital, and a final test must be passed in order to obtain the certificate.

The approximately 900 midwives in The Netherlands have independent practices comparable to a physician in general practice or in a specialty. A few municipalities employ one or more midwives; however, this is not generally the case. Other midwives have full-time posts in maternity hospitals or clinics, while a few have combined their practices in small

maternity clinics of their own. The majority of midwives are found in the towns. Women in families with an income of Fl.6,000 ($1,500) who live in the towns are usually delivered by the midwives; however, in the country most deliveries are by general practitioners. In the large towns, many Dutch women have their babies in maternity hospitals or in clinics, due largely to lack of room and shortage of domestic help. Whenever possible, however, the majority of Dutch babies are born at home.

The "Doctors' Directory" and a special publication issued by the various health insurance companies list the names of all midwives. The expectant mother makes the preferred choice of a midwife in her own district. She then visits the midwife, usually at a maternity center for examination. Further checkups are made at the center. She also may obtain information about her own health and the care of the baby. If any abnormality is detected, the midwife refers the patient to a physician or a specialist.

Expectant mothers in families either not insured at all or insured with one of the many private health insurance companies can decide if the delivery is to be made by a physician or a midwife. A sum fixed on the basis of premium paid is given to a family insured by a private insurance company. Additional expenditures over this amount are paid by the family.

In The Netherlands, State Health Insurance pays the cost of delivery by a midwife if a midwife is available and if the woman is in good health and without indication of complications. State Health Insurance is compulsory for anyone in permanent employment up to an income of Fl.6,000 ($1,500), probably soon to be raised to Fl.6,900 ($1,700). This insurance is handled by a number of approved and state-controlled health insurance companies. All independent workers and people living on small incomes could, up until now, voluntarily join the insurance plan. A proposed bill now being discussed in The Netherlands Parliament will make this insurance compulsory as it is for persons in permanent employment. Everyone with income in excess of Fl.6,000 can insure his or his family's health with a private health insurance company (all are state controlled), and most persons do so. Being insured in either way leaves everyone free to choose his own general practitioner. A certain percentage for medicine is paid by both the compulsory and the private insurance companies. Hospital treatment and specialist attention are included in the state plan up to a certain limit. In the case of private insurance "one can have it anyway one likes it as long as one is willing to pay a higher premium."

FIRST WOMAN PHYSICIAN IN THE NETHERLANDS

Dr. Aletta Jacobs was the first woman physician in The Netherlands and one of the most important women in the movement to obtain the vote for women. She was born in 1854, the eighth child in a family of 11, in a village located in the most northern province of Groningen. Her father was the general practitioner there, and from her earliest days she wished to become a physician like her father, and later like her brothers.

This ambition was considered impossible almost a century ago. However, her father was a considerate man, and, when Aletta found housekeeping an impossible undertaking, he consulted a friend and the two men decided that it would be better to educate her in Greek and Latin.

In 1860 the Government permitted girls to take the examination for apothecary's apprentice. Miss Jacobs became apprenticed to one of her brothers, who was already an apothecary, and in 1870 she passed the examination. She was fully convinced by that time that she would become a doctor of medicine. She attended high school and, carefully studying laws relating to academic studies, found nothing in the laws that forbade women to study at a university. She communicated her desire to study to the Prime Minister, who sought more knowledge of the girl who had written such an unusual letter. She immediately sent all particulars about herself and her plans. The Prime Minister replied that he considered her rather young for a university but that, if her father agreed to her wish, it might be granted. In the spring of 1871 she was given permission to start her medical studies at Groningen University. This unusual procedure was attacked by other universities, but the students and professors defended Aletta.

After completing her work at Groningen she went to Amsterdam University to work on her thesis, obtaining her M.D. degree there in 1879.

She visited in England to study various

problems about the Woman's Suffrage movement and to meet the leading personalities. When she returned to Amsterdam, she became a specialist in women's and children's diseases.

In 1892 she married Dr. Gerritsen, a progressive municipal councilor and alderman. In 1904 she gave up her practice to devote all of her time to improvement of social conditions for women.

The life of Aletta Jacobs has been an inspiration to many women and girls in The Netherlands. In 1881 her sister Charlotte became the first fully graduated apothecary in The Netherlands. In 1894 there were 55 female students at the various Dutch universities. Once Aletta Jacobs had been admitted to academic study, there was no resistance to admission of women. (This is in contrast to the experience in the United States and England where resistance continued for a long time.)

Her experiences in hospitals and in surgery made it clear to her that woman's political suffrage was absolutely necessary. In 1893 she was appointed on the first committee to draft the statutes for the Association for Women's Suffrage; a few years later she became its president. During the Berlin Congress of the International Council of Women, she made The Netherlands the first country to join the International Union for Women's Suffrage, which was founded in Washington in 1892. The second congress took place in Amsterdam in 1908, with 1,200 delegates from 21 countries attending. This congress was reported by the first women journalists.

Dr. Jacobs was successful in attaining the active and passive vote for women landowners on the "Waterscape Councils" (dealing with the water level dikes and the general drainage scheme necessary to keep The Netherlands from flooding); she also succeeded in getting municipal councils to start slum clearance. She was one of the dominant forces for the fight against prostitution. She was one of the founders of the Netherlands' Association of Nurses, and, during the first World War, organized an international Peace Congress in Amsterdam.

In 1919 when women were given the right to vote, Aletta Jacobs said: "Now that we have got the vote, we are no longer powerless. Now it is up to us to see to it that all injustice disappears from our laws and from our society, injustice against women as mothers, as wives, and workers."

NEW PRESIDENT OF MEDICAL SCIENCE ORGANIZATION

Dr. J. W. van den Blink-Rolder was elected president of The Royal Netherlands Company for the Promotion of Medical Science (the exact translation of the name of this organization in The Netherlands), in January, 1958. The organization, founded in 1850, is the official body representing medical science and incorporating all medical practitioners. The opinions of this organization are recognized throughout the world as authoritative.

Dr. van den Blink-Rolder, a former president of The Netherlands Association of Medical Women, is the first woman to be elected President of The Royal Netherlands Company. She has been a member of the Board since 1950.

Dr. Rolder was graduated from Amsterdam University in 1925 and became an assistant at an Amsterdam hospital. She entered general practice a few years later. When she married and became the mother of two children she gave up her practice but was appointed Medical Officer of Health for schools. Six years after this assignment she was appointed as Controlling Medical Officer for a combination of health insurance offices and during the past four years has been acting as the medical advisor for these offices.

(Prepared from material in *Endeavour*, a quarterly publication on information of women in The Netherlands, published by International Archives for the Women's Movement, Amsterdam.)

Opportunities for Women in Medicine

AWARDS

Modern Medical Monographs. The editors of Modern Medical Monographs have offered a $500 award for the best unpublished manuscript for a short book on a clinical subject in the field of internal medicine. Oct. 1, 1958, is the deadline. Information may be obtained from Richard H. Orr, M.D., 37 E. 67th St., New York City 21.

BOOKS WANTED

Do you have any usable medical books of which you would like to dispose?

Physicians and Surgeons Book Company, Henry and Pacific Streets, Brooklyn, N. Y., are interested. Send lists of the books, giving author, title, and date of publication.

COURSES

Occupational Medicine. A full-time course for practicing physicians in Occupational Medicine will be given Sept. 15 through Nov. 7, 1958, by the New York University Post-Graduate Medical School. The course will cover Preventive Medicine, including epidemiology and biostatistics, Administrative Medicine, Occupational Diseases, and Industrial Hygiene. It is aimed at meeting the need for specialized training in industrial medicine. Didactic instruction will be supplemented with field trips to industrial plants, governmental agencies concerned with industrial health, and to union health centers. Opportunity will be given to attend medical, surgical, and clinicopathological conferences held in the New York University-Bellevue Medical Center. For further information write to Office of the Associate Dean, NYU Post-Graduate Medical School, 550 First Ave. New York City 16.

FELLOWSHIPS

Developmental Diagnosis. The Clinic of Child Development, sponsored jointly by the Department of Pediatrics, Ohio State University College of Medicine, Columbus, the Children's Hospital of Columbus, and the Ohio State Department of Mental Hygiene and Correction, has announced availability of fellowships in developmental diagnosis to pediatricians or psychiatrists who are board-eligible. They are for a period of one year, beginning July 1, with one position available each six months. The stipend is $5,000. Inquiries should be directed to Dr. Hilda R. Knobloch, Director of the Clinic of Child Development, Children's Hospital, 561 S. 17th St., Columbus 5, Ohio.

MEETINGS

Air Pollution. A national conference to study the problem of air pollution will be held in Washington, D.C., the week of Nov. 15, 1958. Dr. Leroy E. Burney, Surgeon General, will preside over the conference and has called the meeting to assess the midpoint progress of a five year program of research and technical assistance to states on the growing air pollution problem.

American Congress of Physical Medicine and Rehabilitation. The 36th Annual Scientific and Clinical Session of the Congress will be held Aug. 24-29 at the Bellevue-Stratford Hotel in Philadelphia. The scientific program will be open to all members of AMA.

Cell Chemistry Conference. A Conference on the Chemical Organization of Cells will be held in Madison, Wis., Aug. 21-23. Dr. Joseph J. Lalich, Professor of Pathology, University of Wisconsin, Madison 6, is in charge of information. A number of travel stipends may become available, and advance registrants will be notified of the stipends by Dr. Lalich.

International Society of Audiology. The Society's Fourth Congress will be held in Padua, Italy, Oct. 2-5, 1958. The conference is reserved for audiologists who are particularly interested in the progress of this specialty. The Fifth Congress will be held in 1960 in Basel, Switzerland. Correspondence should be addressed to General Secretary of Fourth Congress of the International Society of Audiology, Prof. Arslan, Clinique O.R.L., Universitaire, Padua, Italy.

Wisconsin Academy of General Practice. The Academy will meet in Milwaukee Sept.

15-16. Applications for a limited number of exhibits will be accepted. Information may be obtained from Mr. Robert A. Dufour, Executive Secretary, Wisconsin Academy of General Practice, 758 N. 27th St., Milwaukee 8.

POSITIONS AVAILABLE

Illinois. Dr. Ruth E. Church, Deputy Directory, Division of Hospitals and Chronic Illness, Department of Public Health, Room 518 State Office Building, Springfield, Ill., has announced openings for two physicians, preferably with public health training: one is to develop a geriatrics program; the other is to work in the cancer and heart disease program. The positions are available to either sex. The applicants have to meet Civil Service requirements before a permanent appointment is granted, and a license to practice medicine in the state of Illinois will be required before a permanent appointment. Salary range is $749-$915 per month. Inquiries should be directed to Dr. Church at the above address.

New York. Dr. Benjamin Jablons, Director, Open Medical Division, Goldwater Memorial Hospital, Welfare Island 17, N. Y., has announced several vacancies on the attending staff and on the house staff of the open medical division.

TEACHING AWARDS

Peru and India. Five awards in medical education in Peru are available from April, 1959, to December, 1959, through the U.S. Government awards under the Fulbright and Smith-Mundt Acts. The following specialists have been requested: physiology and pharmacology, University of Arequipa; physiology, University of Trujillo; anatomy and histology, School of Medicine, Catholic University; and biophysics, University of San Marcos.

The same agency has received requests for American professors to teach at Indian universities: neurosurgery, Christian Medical College, Vellore; and medical science, Utkal University. Universities in South India open in June and those in North India in July; both close in March or April.

For additional information write to Conference Board Committee on International Exchange of Persons, 2101 Constitution Ave., Washington 25, D.C.

THESE WERE THE FIRST

DR. LEONI NEUMANN CLAMAN, graduate of Columbia University College of Physicians and Surgeons in 1934, was appointed in 1938 as head of the Allergy Service at the New York Infirmary, which post she now occupies, and since 1942 has been a staff allergist in the Roosevelt Hospital Institute of Allergy. Dr. Claman in 1957 was elected president of the New York Allergy Society (formerly the Association of Approved Allergy Clinics), and is the first woman to be so honored. Previous to her election, Dr. Claman was the first and only woman to head a committee on public relations in the American Academy of Allergy, of which she is a fellow.

DR. ANNA MANNING COMFORT (born in 1845) of Trenton, N.J., who studied medicine with her aunt, Dr. Clemence Lozier, and then was graduated from the New York Medical College for Women in the first class admitting women, was the first woman to practice medicine in Connecticut. In 1870 Dr. Comfort went to New York, retiring in 1892. Her husband, Prof. G. F. Comfort, was founder of the College of Fine Arts in Syracuse, N. Y.

DR. ELMIRA Y. HOWARD (born in 1841) of Shelby, Richmond County, Ohio, studied medicine after the death of her husband, an artist (Jerome Howard) who died in Andersonville Prison. Dr. Howard, a graduate from the New York Medical College for Women, went to Cincinnati and was the first woman physician in that city. Dr. Howard studied in Vienna and was correspondent for the *Cincinnati Gazette* while abroad.

DR. RUTH JACKSON (born in 1902) of Jefferson, Iowa, graduated from Baylor University College of Medicine in 1929, and in 1941 was the only woman member of the American Academy of Orthopedic Surgeons. Dr. Jackson practices in Dallas, Texas.

DR. MARY JEANNETTE KEARSLEY, Chicago, Ill., graduated from Woman's Medical College of Northwestern University in 1888 and was the first and only woman to be elected president of the Aux Plaines Branch of the Chicago Medical Society. A banquet was given in her honor in 1937 when she completed 50 years of practice.

—From the ELIZABETH BASS Collection, Rudolph Matas Medical Library, Tulane University, New Orleans.

News of Women in Medicine

Dr. Agnes V. Bartlett of Springfield, Vt., was elected secretary-treasurer of the New Hampshire Society of Anesthesiologists at their recent annual meeting.

Dr. Victoria L. M. Cass, Associate Director of Peter Bent Brigham Hospital in Boston, has been appointed to serve as acting director until Dr. Floyd Mussels assumes the duties of director on June 15.

Dr. Martha M. Eliot, Chairman of the Department of Maternal and Child Health at Harvard School of Public Health, Boston, received an honorary doctor of science degree from Wayne State University, Detroit, on Jan. 28.

Dr. Patricia A. Foust of Cleveland and Dr. Adele Sismondo of Baltimore were certified as fellows of the American College of Anesthesiologists on Jan. 7 and Jan. 15 respectively.

Dr. Dorothy M. Horstmann, F.A.C.P., Associate Professor of Preventive Medicine, Yale University School of Medicine, New Haven, Conn., spoke on "Enteric (ECHO) Virus Infections and Clinical Disease" at a General Session of the American College of Physicians, held in Atlantic City, N. J., April 28-May 2, 1958. Other women physicians appearing on the program were: Dr. Janet W. McArthur, F.A.C.P., Clinical Associate in Medicine, Harvard Medical School, Boston, member of a panel that discussed "The Internist's Responsibility in Gynecology"; Dr. Helena E. Riggs, Assistant Professor of Neuropathology, University of Pennsylvania Graduate School of Medicine, who appeared by invitation to participate in a panel discussion of "Subarachnoid Hemorrhage and Intercranial Aneurysms"; Dr. Myra Zinke, trainee at the National Institutes of Health, who participated by invitation in the Clinic Sessions on "Functional Evaluation of Hepato-Biliary Disease"; and Dr. Florence I. Mahoney, F.A.C.P., Associate Professor of Physical Medicine, University of Maryland School of Medicine, who participated in a panel discussion of "Rehabilitation of the Hemiplegic Patient."

Dr. Katherine Hsu, pediatrician of Houston, was a special speaker in a panel discussion on "Newer Trends in Management of Tuberculosis in Adults and Children" during a meeting of the Section on Internal Medicine and Section on Pediatrics of the Texas State Medical Association. Dr. Murdina M. Desmond, also of Houston, spoke on "Respiratory Distress in the Newborn Infant" during the meeting of the Section on Pediatrics.

Dr. Evelyn Lorenzen of Houston was sponsor for a panel discussion with audience participation at a recent meeting of the Texas Neuropsychiatric Association. Dr. Barbara Korsch, Clinical Director, Pediatric Outpatient Department, New York Hospital, New York City, appeared on the same program.

Dr. Esther P. Lovejoy, Dr. Elise L'Esperance, Dr. Ada Chree Reid, and Dr. Edith Alexander have been chosen to receive certificates of honorary membership in the Philippine Medical Women's Association. The certificates are to be presented at the 1958 Annual Meeting of the Philippine Association, according to an item in the PMWA News Letter.

Dr. Kathryn P. Noble of Fremont, Ohio, has become an associate of Dr. John F. Morres in the practice of anesthesiology in Huntington, W. Va.

Dr. May Owen of Fort Worth, Texas, was the recipient of the Texas Society of Pathologists George T. Caldwell award. Dr. Owen, a past-president of that society, was chosen Medical Woman of the Year by the Dallas Branch of AMWA in 1956.

Dr. Katharine W. Wright, President-Elect of AMWA, attended the Thirty-Fifth Annual Meeting of the American Orthopsychiatric Association in New York City, March 6-8.

ALBUM OF WOMEN IN MEDICINE

PAULA HORN, M.D.

Paula Horn was born and raised in Iowa. Her father and grandfather were Lutheran ministers. This religious background is manifested in Paula by her great devotion and service to her patients.

She attended the University of Iowa and graduated from the University of Iowa School of Medicine in 1932. She interned at the Los Angeles County General Hospital from 1932 to 1934. Because of her administrative ability she became assistant medical director of this hospital and held this position for six years. She discontinued her administrative job in 1940 to start a three year residency in her chosen field of obstetrics and gynecology at the General Hospital. Her well-planned training was rounded out by another three years as chief resident in obstetrics and gynecology.

Dr. Horn's resident training was broadened by her experiences as obstetrical consultant in contagious diseases. She modestly states that because of the absence of senior attending men during the war she started delivering patients with poliomyelitis. In 1948 during a poliomyelitis epidemic Dr. Horn and her associates delivered their first baby by cesarean section in a respirator case. Recognition in this field was given several years ago when she was asked by the International Congress of Gynecology and Obstetrics to address its annual meeting in Geneva, Switzerland, on "Pregnancy Complicated by Poliomyelitis."

At the conclusion of her resident training Dr. Horn became a diplomate of the American Board of Obstetrics and Gynecology and then went into private practice in Los Angeles. She has rightly enjoyed a successful and rewarding practice.

Besides having a time-consuming practice, Dr. Horn found time to become a fellow in the American College of Obstetrics and Gynecology, in the American College of Surgeons, and in the International College of Surgeons. She also is associate clinical professor of obstetrics and gynecology at the School of Medicine, University of Southern California, and attending obstetrician and gynecologist at the Hospital of the Good Samaritan and Los Angeles County General Hospital.

Any person who comes in contact with Dr. Paula Horn is impressed with her sincerity of purpose and her sympathetic attitude. She has the courage to face difficult situations and to be forthright with her patients. She honorably represents the art and the science of medicine.

—Dorothy J. Lyons, M.D.

Book Notices

Editor's Note: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

MICROTECHNIQUES OF CLINICAL CHEMISTRY FOR THE ROUTINE LABORATORY. By Samuel Natelson, Sc.M., Ph.D., Chairman, Department of Biochemistry, Rockford Memorial Hospital, Rockford, Ill. Pp. 484. Price $11.00. Charles C Thomas, Springfield, Ill., 1957.

This book, for use in the clinical laboratories, begins by clarifying the term "micromethod." Whereas not too long ago the use of 1 cc. of blood was considered a micromethod, it is now considered a macromethod; use of 0.1 cc. of blood is now a micromethod, and the use of 0.025 cc. is the ultramicromethod (especially recommended in the case of infants).

The author presents the methods, and often a choice of methods, to use in all clinical tests made in most laboratories. In each case the formula is given clearly and the solutions to be used are accurately described.

The book includes a bibliography of other authors' books on the same subjects and a list of manufacturers of microchemical equipment. An appendix explains the physical reactions of less frequently performed tests as well as the statistical evaluation of the methods described. This is an extremely worth-while book to have at hand in any clinical laboratory.

—Ruth Theis, A.B.

MODERN PRENATAL CARE. Edited by Leslie V. Dill, M.D., F.A.C.S., Diplomate of the American Board of Obstetrics and Gynecology; Associate Clinical Professor, Obstetrics and Gynecology, Georgetown University School of Medicine; Consultant, Obstetrics and Gynecology, Army Medical School and Walter Reed General Hospital; and Staff Member, Obstetrics and Gynecology, Providence Hospital, Washington, D.C. Pp. 309, with 51 illustrations. Price $6.50 (paper). Appleton-Century-Crofts, Inc., New York, 1957.

This book is concise, simply and clearly written, and printed in easily legible type. It covers the subject of up-to-date prenatal and postpartum care, starting with an interesting chapter on the evolution of obstetrics. This is followed by chapters on manifestations and hygiene of pregnancy and nutrition during this period, with a description of present-day methods on diagnosis and care. The chapter on pelvic mensuration gives the important diameters, methods for clinical evaluation, and indications for roentgenographic pelvimetry. It cites briefly the methods of Caldwell and Moloy, Thomas, and Mengert, and the merits of each.

The obstetric problems discussed include abortion, toxemias and anemias of pregnancy, and the fourth stage of labor, with schedules of therapy for the various conditions. This is followed by discussions on complications to pregnancy such as heart disease, diabetes mellitus, thyroid disease, venereal disease, and tuberculosis. There are also schedules of therapy for these various diseases.

The chapter on psychology of pregnancy is a good reminder to be constantly alerted to the psychotic or the probably psychotic and to have psychiatric therapy instituted when symptoms are manifested. The discussion on obstetrical records is basically the same as that required by the hospital accreditation boards.

A few chapters are devoted to the problems of the fetus: fetal and neonatal mortality, birth injuries, congenital abnormalities, erythroblastosis, and infant feeding. The chapter on the practice of obstetrics and the law is concise and gives the basic principles and their application to physicians who practice obstetrics. The book ends with a chapter on the ethics of the Catholic church as they pertain to obstetrics. This should be helpful to non-Catholic physicians handling Catholic patients.

This book should be very informative for those who handle an occasional patient, and a good check for those who devote their practices largely or wholly to obstetrics.

—Ellen F. Leong, M.D.

HANDBOOK OF DIFFERENTIAL DIAGNOSIS. By Harold Thomas Hyman, M.D. Second Edition. Pp. 801. Price $6.75. J. B. Lippincott Company, Philadelphia, 1957.

This is an exceedingly useful reference book as to size, arrangement, and content. Almost every conceivable sign or symptom is listed in alphabetical order in the index, which occupies the first portion of the book. The sign or symptom is described in the pages that follow: physiological changes, causative factors, diagnostic procedures, and therapy are all covered. Several charts are also included.

Dr. Hyman has added many new sections to this second edition of the book. It is surprising how much information he can crowd into so compact a work, the arrangement of which is excellent. It can be recommended to intern and practicing physician alike.

—Adelaide Romaine, M.D.

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1. Arner, O., and Others: Nord. med. *58*:1346 (Sept. 12) 1957.
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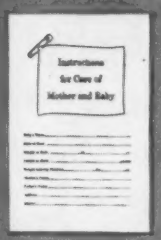

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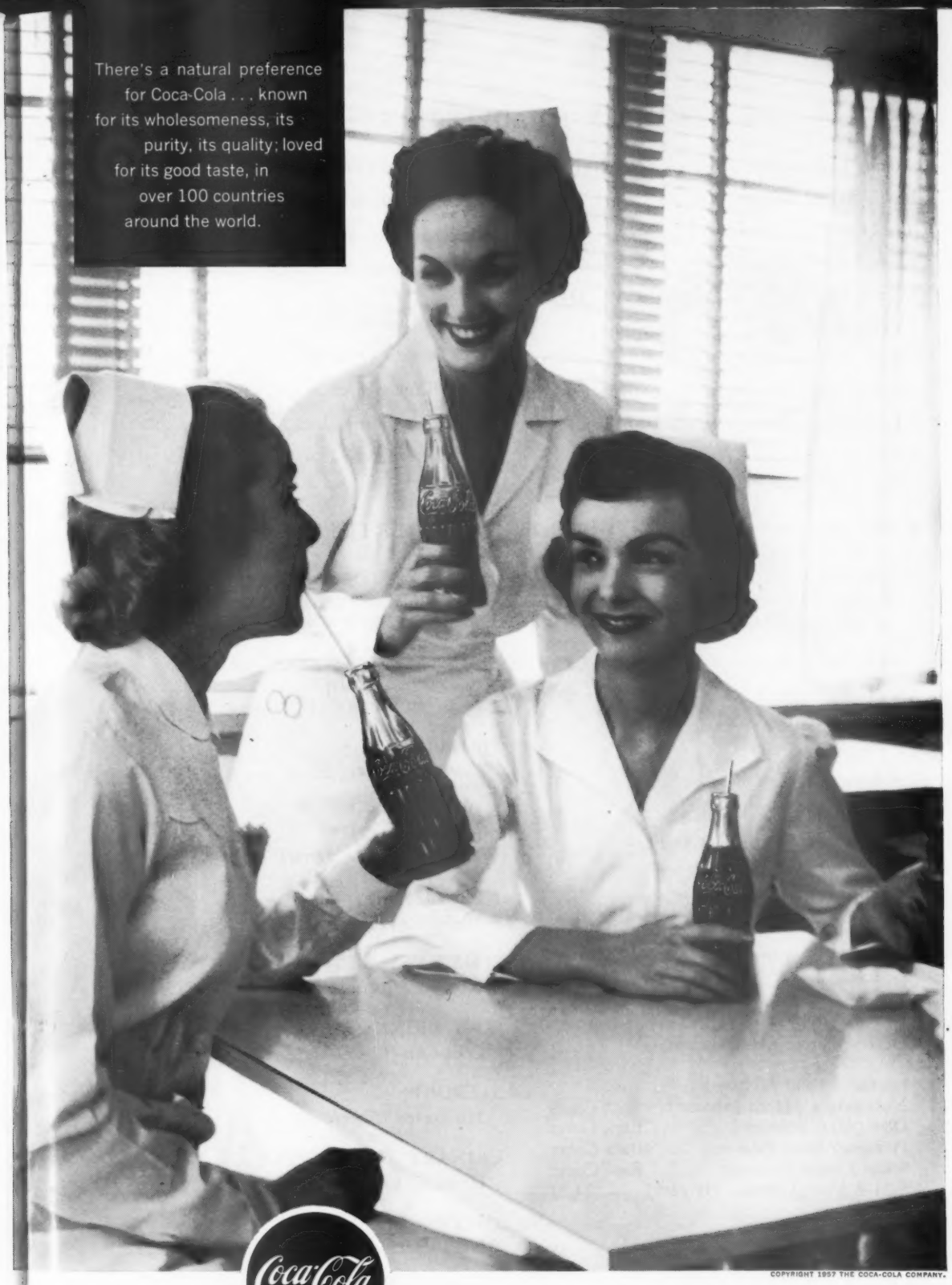

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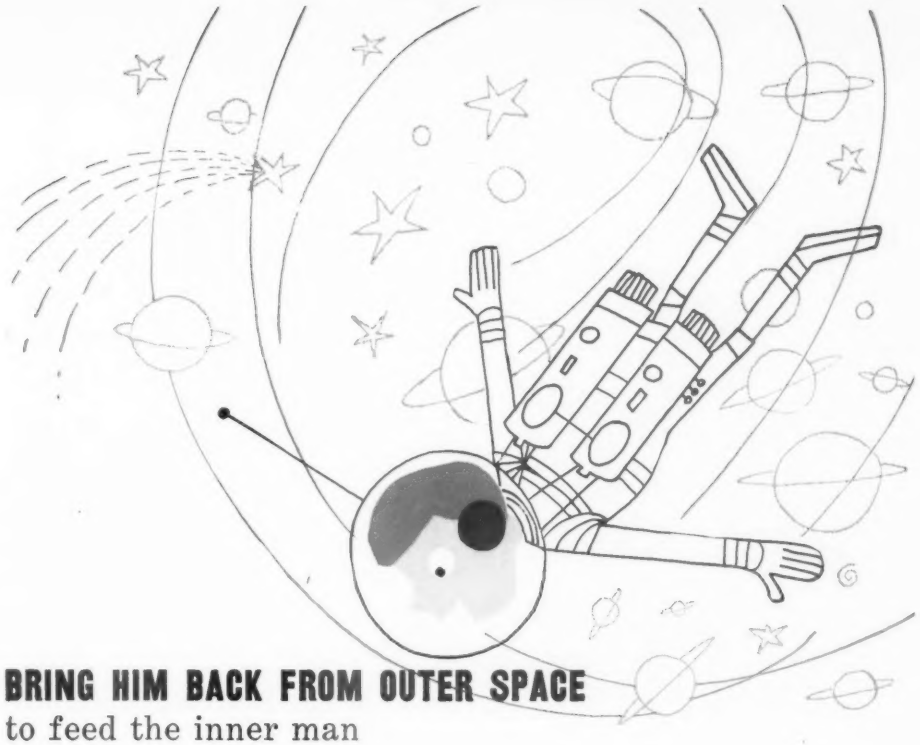

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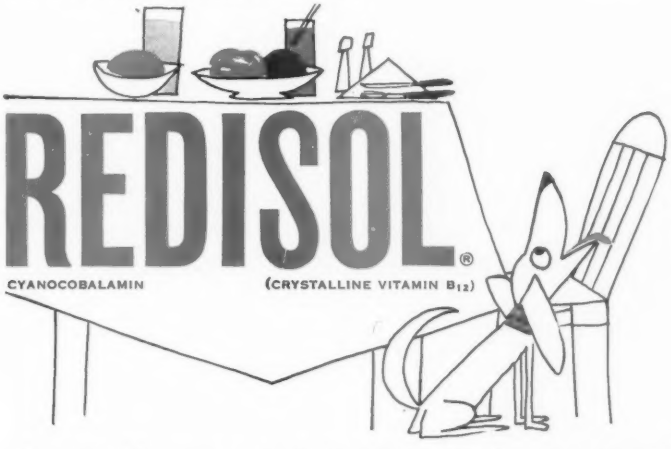

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